UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 26 January 2022

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 26 January 2022 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 26 January 2022

Time	Item		Method	Purpose	Lead
13:15	**1**	Welcome, Introductions, Apologies & Quorum • Chief Executive Award	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**		**Chair**
	3	Patient Story	**Slides**	**Discussion**	**CNO**
	4	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 24 November 2021	**Paper**	**Approval**	**Chair**
	5	Matters Arising - Action List	**Paper**	**Review**	**Chair**
	6	Chief Executive Officer's Report	**Paper**	**Noting**	**CEO**
13:45	**7**	**QUALITY AND PERFORMANCE**			
	7.1	Update on Covid and Winter	**Slides**	**Discussion**	**CNO/ COO**
	7.2	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Discussion**	**EDs**
	7.3	Staffing Assurance Framework for Winter 2021	**Paper**	**Noting**	**CNO**
14:30	**8**	**STRATEGY AND TRANSFORMATION**			
	8.1	Maternity Continuity of Carer Plan	**Paper**	**Endorsement**	**CNO**

14:50	**9**	**GOVERNANCE**			
	9.1	Sustainability Committee Terms of Reference	**Paper**	**Approval**	**Deputy Co Sec**
	9.2	Transformation Committee Terms of Reference	**Paper**	**Approval**	**Deputy Co Sec**
	9.3	Quality Committee Terms of Reference	**Paper**	**Approval**	**Deputy Co Sec**
	9.4	Board of Director Governance Cycle	**Paper**	**Approval**	**Deputy Co Sec**
15:05	**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 23 January 2022 to sarah.locke@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 30 March 2022 at 13:15 via Microsoft Teams Future Meeting Dates: 25 May 2022, 27 July 2022, 28 September 2022 and 30 November 2022			
	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 26 January 2022

Time	Item		Method	Purpose	Lead
15:30	**16**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	17	Declarations of Interest	**Verbal**		**Chair**
	18	For Accuracy and to Agree: Part 2 Minutes of meeting held on 24 November 2021	**Paper**	**Approval**	**Chair**
	19	For Accuracy and to Agree: Part 2 Minutes of meeting held on 15 December 2021	**Paper**	**Approval**	**Chair**
	20	Matters Arising – Action List	**Paper**	**Review**	**Chair**
15:40	**21**	**QUALITY, PERFORMANCE & RISK**			
	21.1	Risk Register Report: Risks 12 and Above	**Paper**	**Approval**	**CNO**
	21.2	Serious Incident Report	**Paper**	**Discussion**	**CMO**
	21.3	Covid Outbreak Report and Action Plan	**Paper**	**Endorsement**	**CNO**
	21.4	Update on PPE	**Verbal**	**Noting**	**CNO**
	21.5	Health Inequalities Update	**Paper***	**Decision**	**CFO**
16:10	**22**	**STRATEGY AND TRANSFORMATION**			
	22.1	ICS/B Update	**Verbal**	**Noting**	**CEO**
	23	**GOVERNANCE**			
	23.1	IHP Contract	**Paper**	**Approval**	**CSTO**
	23.2	Refurbishment Works Across UHD	**Paper**	**Ratification**	**Chair**
	23.3	Poole Theatres Design	**Paper**	**Ratification**	**Chair**
	23.4	Development and Delivery of a Care Hotel	**Paper**	**Ratification**	**Chair**
	23.5	Contrast Media and Barium	**Paper**	**Approval**	**CFO**
	23.6	Phillips Radiology Maintenance	**Paper**	**Approval**	**CFO**
	23.7	PCI Consumables	**Paper**	**Approval**	**CFO**
	24	External Review of Maternity Serious Incidents and Learning	**Verbal**	**Discussion**	**CNO**

	25	Exception Reports from the Chairs of the Board Committees	**Verbal**	**Noting**	**Chair**
16:55	**26**	Any Other Business	**Verbal**		**Chair**
	27	Reflections on the Board Meeting	**Verbal**		**Chair**
	28	**Date and Time of Next Private Board Meeting:** Board of Directors Part 2 Meeting on Wednesday 23 February 2022 via Microsoft Teams. Future Meetings: Wednesday 30 March 2022 and Wednesday 27 April 2022.			
17:00	**29**	**Close**	**Verbal**		**Chair**

* late paper

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Board of Directors Part 1 meeting held on Wednesday 24 November 2021 at 13:15 via Microsoft Teams.

Present:	David Moss	Non-Executive Director, Chair
	Caroline Tapster	Non-Executive Director
	John Lelliott	Non-Executive Director
	Cliff Shearman	Non-Executive Director
	Pankaj Davé	Non-Executive Director
	Christine Hallett	Non-Executive Director
	Philip Green	Non-Executive Director
	Debbie Fleming	Chief Executive
	Paula Shobbrook	Chief Nursing Officer
	Alyson O'Donnell	Chief Medical Officer
	Pete Papworth	Chief Finance Officer
	Mark Mould	Chief Operating Officer
	Richard Renaut	Chief Strategy & Transformation Officer
	Karen Allman	Chief People Officer
	Peter Gill	Chief Informatics Officer
In attendance:	John Vinney	Associate Non-Executive Director, Vice-Chancellor Bournemouth University
	James Donald	Associate Director of Communications
	Fiona Ritchie	Company Secretary
	Ewan Gauvin	Corporate Governance Assistant (minutes)
	Zoe Jones	Corporate Governance Manager (item 3)
	Wendy Copping	Deputy Clinical Lead, Early Pregnancy Clinic (item 3)

BoD 171/21	**Welcome, Introductions, Apologies & Quorum** The Chair welcomed everyone to the meeting. Apologies were received from Stephen Mount, Non-Executive Director. The meeting was declared quorate.
BoD 172/21	**Declarations of Interest** There were no further declarations of interest.
BoD 173/21	**Patient Story** The Chief Nursing Officer introduced the Patient Story. The Board were presented with a video following Suzanne, a patient who had suffered multiple miscarriages. Feeling that more support was

	required for patients leaving hospital after a miscarriage she formed the group "Our Angel Bears". The group worked with the Trust to introduce packages, containing small handmade gifts for patients. Since the work began at the Royal Bournemouth Hospital, this group has expanded to supporting patients in over 20 hospitals around the country. Furthermore, alongside the deputy clinical lead for the Early Pregnancy Clinic, a support group was established, held every 6 to 8 weeks. The group became a registered charity in July 2021. Wendy Copping, Deputy Clinical Lead for the Early Pregnancy Clinic, who had been supporting Suzanne, emphasised the importance of the support that the charity provided. It had been a huge success and had a real impact on patients. The Board commended the charity and the deputy clinical lead for her support.
BoD 174/21	**Minutes of the Board of Directors Part 1 Meeting held on 29 September 2021** The Chief Nursing Officer clarified that the word "critical" should be replaced with "clinical" in the second paragraph of minute **BoD 158/21.** The Board APPROVED the minutes as an accurate record of the meeting, subject to the above correction.
BoD 175/21	**Matters Arising – Action List** The Chair advised that both actions had been completed. The Board CLOSED actions BoD151/21 and BoD157/21
BoD 176/21	**Chief Executive Officer's Report** The Chief Executive presented the report, highlighting the following key points: • At the time of the meeting there were 76 patients with Covid in the Trust, including 10 in ITU. Separate pathways were critical to manage this. • High local infection rates were affecting staffing, with 138 members of staff impacted. • Development plans were being devised to tackle health inequalities in the community. • Recruitment of the new Chief Executive was progressing well. Interviews would be held in December 2021. • Patricia Miller had been appointed Chief Executive Designate of the Integrated Care Board (ICB). • A successful engagement event had been held at the Dolphin Centre in Poole. • Estates development was progressing well. • Three remembrance events were held across the Trust. A Non-Executive Director questioned what was being done to support

	staff. The Chief Executive replied that the top priority was to have as much capacity as possible and maintain safe staffing levels in order to improve flow and decrease pressure on staff. There were a number of support systems in place for members of staff to use should they need them. The Board NOTED the Chief Executive Officer's report.
BoD 177/21	**Integrated Quality, Performance, Workforce and Finance Report** The Chair introduced the report, comprising updates from a number of Executive Directors. **Operations:** The Chief Operating Officer presented the operational performance report, highlighting the following key points: • Increase in Covid admissions from 19 on 29th September 2021 to 76 on the 24th November 2021. • Waiting lists continued to increase, however the amount of time spent waiting was beginning to decrease. • There was a significant focus on patients waiting over 104 weeks. The Chief Executive had participated in a number of regional meetings to outline plans. • Estimates suggested that 38 patients would be waiting more than 104 weeks by the end of March 2022. This was as a result of patient choice. • Diagnostic six week performance increased 5.6% to 95%. • There was significant pressure on the Emergency Department which was having an impact on crowding and ambulance handovers. • There had been a 20% increase in cancer referrals. A range of plans were being put in place to cope with demand, however this was stretching two-week cancer referrals. • 62 day cancer treatment was a challenge. • There were over 180 patients who did not meet the Criteria to reside (C2R). Discussions continued with the wider system and a number of actions were in place. **Quality:** The Chief Nursing Officer presented the quality report, highlighting the following key points: • The rate of Covid cases in the Bournemouth, Christchurch & Poole Council (BCP) area was higher than the national average. • The November 2021 Quality Committee had reviewed the Covid outbreak report, and would be presented to the January 2022 Board of Directors meeting. • There was good oversight of Infection Prevention & Control (IPC) and reporting was being aligned for UHD. • There had been an increase in Friends & Family Test (FFT) responses, with positive results received particularly in maternity. • A deep dive on falls was being undertaken.

	ACTION: To present the Covid Outbreak Report to the January 2022 Board of Directors meeting. **Paula Shobbrook.** The Chief Medical Officer added that there had been a significant downward trend in the Standardised Mortality Ratio (SMR). A return to the Summary Hospital-Level Mortality Indicator (SHMI), which was the NHSE/I recognised metric, was being considered. **Workforce:** The Chief People Officer presented the workforce report, highlighting the following key points: • Turn-over remained at around 12% over the previous 12 months. • There had been a significant amount of recruitment activity, with a focus on expanding reach. • An advanced occupational health service was being considered alongside further work on vaccinations in order to combat increased sickness rates. • Appraisal levels had increased, with further work on-going. • Mandatory training compliance continued to be greater than 80% despite some sessions being on hold due to operational pressures. • There remained a strong reliance on temporary workforce. **Finance:** The Chief Finance Officer presented the finance report, highlighting the following key points: • The H2 budget, for the second half of the financial year, would be discussed in detail with a view to being approved at the Board of Directors Part 2 meeting. • The H2 budget contained significant financial risk, specifically relating to the cost improvement target of £10.1m when combined with the H1 (first half of the financial year) requirements. Operational pressures would make this a substantial challenge. There was only confidence in achieving a cost improvement of £4.2m, and therefore financial risk of £5.9m. • Two revenue related risks had been increased, reflecting the increased likelihood of reporting a deficit at the end of the financial year. • A deficit of £83,000 was delivered in October 2021 against a planned deficit of £80,000. • Year-to-date the reported deficit was £611,000. • The Trust was in an under-spend position against the capital programme. • The cash balance had improved following the receipt of the pay award funding and elective recovery funding. • The Trust was slightly behind the better payment practice code target of 95%, being at 93%. The Board NOTED the Integrated Quality, Performance, Workforce and Finance report.
BoD 178/21	**Quality Impact Assessment Overview Report**

	The Chief Nursing Officer presented the Quality Impact Assessment Overview report, highlighting the following key points: • All schemes required sign-off by the Chief Nursing Officer and Chief Medical Officer. • This report had been reviewed at the October 2021 Quality Committee, with schemes being regularly reviewed through the Finance & Performance Committee. • There had been a staffing guidance update from NHSE/I which included some additional requirements for the Chief Nursing Officer and Chief Medical Officer. The guidance was being reviewed and the Quality Impact Assessment policy would subsequently be updated and presented to the Board of Directors. **ACTION:** To present the updated Quality Impact Assessment policy to the January 2022 Board of Directors meeting. **Paula Shobbrook** The Board NOTED the Quality Impact Assessment Overview report.
BoD 179/21	**Emergency Preparedness, Resilience and Response Core Standards** The Chief Operating Officer presented the Emergency Preparedness, Resilience and Response Core Standards, highlighting the following key points: • The Trust was fully compliant against 64 core standards and partially compliant against 4 core standards. • The 4 partially compliant standards were: - Data protection; the toolkit would be submitted in January 2022. - Chemical, biological, radiological and nuclear (CBRN) capacity; further training would occur on the Royal Bournemouth Hospital site to work towards full compliance. - Mutual aid; further work was on-going with workforce directors across the wider system. - Business continuity audit; this would be taken to the Audit Committee to demonstrate full compliance. • The Trust was "substantially compliant" overall, in line with other organisations across Dorset. The Board APPROVED the Emergency Preparedness, Resilience and Response Core Standards.
BoD 180/21	**Mortality Report – Quarter 2** The Chief Medical Officer presented the Mortality Report for Quarter 2, highlighting the following key points: • There were improvements in the metrics, with 2 out of 3 being "better than expected" and 1 being "as expected". • There remained a discrepancy between sites for two metrics and the investigation into this continued. • Covid deaths on the Poole site were having a disproportionate impact on the metrics compared to the Royal Bournemouth Hospital.

	• SHMI data had been challenged by the Trust and sent back to the national team due to errors in the data. • DoctorFoster was running four months behind for benchmarking data which would provide an additional challenge over the winter period. • Themes identified in the Medical Examiner's report were being actioned. A Non-Executive Director, in their role as Chair of the Quality Committee assured the Board that mortality was regularly reviewed at the Quality Committee and that any issues identified would be investigated immediately despite the delays in national benchmarking. The Board NOTED the Mortality Report for Quarter 2.
BoD 181/21	**Annual Safeguarding Report** The Chief Nursing Officer presented the Annual Safeguarding Report, highlighting the following key points: • The report would be published on the Trust website following the Board's approval. • The report had been initially presented to the Safeguarding Group and then to the October 2021 Quality Committee. • Positive feedback had been received from across Dorset, particularly about the collaboration across organisations. • Cases of domestic violence had increased as a result of the Covid-19 pandemic. • The Trust was part of the Pan-Dorset safeguarding children partnership and the adult safeguarding boards. • Areas of work included a review of safeguarding reporting in the Emergency Department, scrutiny of the child protection medical examiners process and the Trust had received a Bournemouth, Christchurch & Poole Council Ofsted visit. • Mandatory training was being carefully monitored. The Chief Medical Officer, with regards to the consultant safeguarding rota risk, added that a community paediatrician had been appointed in November 2021 who would contribute to the safeguarding rota. **ACTION:** To circulate the Safeguarding Statement of Compliance to members of the Board of Directors. **Paula Shobbrook.** The Board was ASSURED by the Annual Safeguarding Report and APPROVED the Annual Statement of Compliance, subject to its circulation to members of the Board.
BoD 182/21	**Covid Mortality Review** The Chief Medical Officer presented the Covid Mortality Review, highlighting the following key points: • The report had been presented to the October 2021 Quality Committee and the wider Dorset system. • The report was a high-level summary of wider work, which included

	post-infection reviews for every outbreak and mortality reviews. • Feedback commended the robustness of the report compared to similar reports from other organisations. • Patients that had cognitive impairments or that were medically ready for discharge accounted for around a third of cases of hospital acquired Covid. This had been highlighted to local safeguarding teams. • Different methodology had been used between sites. This was due to the focus on the large initial outbreak which occurred at Poole. • Themes included multiple moves of patients and swabbing, the guidance on which had changed following the initial outbreak. The Chief Executive commended the level of detail included in the report, adding that it was important to reflect on the sadness associated with the report and the impact on patients and staff. The Board NOTED the Covid Mortality Review.
BoD 183/21	**Annual Infection Prevention & Control Report 20/21** The Chief Nursing Officer presented the Annual Infection Prevention & Control Report, highlighting the following key points: • The report did not include Covid cases. A separate Covid outbreak report would be presented to the January 2022 Board of Directors meeting. • The report demonstrated the Trust was meeting the Care Quality Commission (CQC) Code of Practice and legal requirements. • The Trust had a dedicated Infection Prevention & Control team. • Below the England average for levels of Clostridium Difficile (C.Diff) and hospital attributed cases had been reduced. • There were low levels of methicillin-resistant Staphylococcus aureus (MRSA) – 3 cases that were community associated. • Levels of methicillin-susceptible Staphylococcus aureus (MSSA) and Escherichia coli (E.Coli) in Dorset were higher than the national average. There was a number of on-going quality improvement projects associated with this. • There were several audits included in the report; cleaning, hand hygiene, cleaning of medical devices and estates. • Next steps included a review of hand washing basins. • The Trust had full clinical pathology accreditation and ICNET clinical surveillance software was now in use. • The report would be included on the Trust website along with the statement of commitment. **ACTION:** To circulate the infection prevention & control statement of commitment to members of the Board of Directors. **Paula Shobbrook.** Non-Executive Directors commended the work of the Infection Prevention & Control team but asked whether there would be a refocus to surgical site infections. The Chief Nursing Officer assured the Board that Paul Bolton, Lead Infection Prevention & Control Nurse was working with surgical teams to re-establish this area of work. The Board were ASSURED by the Annual Infection Prevention & Control

	Report and APPROVED the statement of commitment subject to its circulation to members of the Board.
BoD 184/21	**Annual Winter Plan** The Chief Operating Officer presented the Annual Winter Plan, highlighting the following key points: • The plan was continually developing and would take into account any new guidance received. • Aspects of the plan included: - Bed modelling - Clear escalation plans - Lessons learnt from previous years - Additional winter investment of around £5m - Alignment with the wider system • There remains a challenge in January and February 2022 with regards to managing capacity. • The biggest risk was noted as the dependency on other partners, in particular the local authorities. • A specific plan would be developed for Christmas and New Year. The Board APPROVED the Annual Winter Plan.
BoD 185/21	**Bournemouth University UHD Partnership Annual Report** The Chief Strategy & Transformation Officer presented the Bournemouth University – UHD Partnership Annual Report, highlighting the following key points: • Six objectives had been set, the progress against which had been included in the report: - Greater alignment - Stimulus for research and innovation - Education and training of future workforce - Recruit and retain talent - Meeting future challenges - Wider private and public partnerships • There had been excellent engagement throughout the partnership from the Deans of the University. The Chief Executive informed that Board that she had attended a very positive meeting of the partnership board and would meet with John Vinney, Vice-Chancellor of Bournemouth University and Associate Non-Executive Director UHD throughout the year to ensure strategic alignment of the partnership. The Chief Nursing Officer added that the partnership was inspiring for staff and that engagement was incredibly positive. The Vice-Chancellor of Bournemouth University echoed the previous comments and was looking forward to the further development of the partnership. The Board NOTED the Bournemouth University – UHD Partnership Annual

	Report.
BoD 186/21	**Digital Transformation Strategy** The Chief Informatics Officer presented the Digital Transformation Strategy, highlighting the following key points: • The slides had been presented to Mark Cubbon, Interim Chief Operating Officer for NHSE/I in October 2021. • 50,000 records were accessed using the Dorset Care Record in October 2021, 30,000 of which were from UHD. • Single Sign-on had been deployed with 4,400 users and 70 applications at the time of the meeting. There had been 25,000 login events using this system on the previous day. This was saving over 200 hours of staff time per day. • The Board had agreed to rolling IT stock replacement in September 2021. • The Trust had an excellent in-house development team, with the electronic observations (eObs) and electronic nursing assessment (eNA) platforms being a particular success. • Close to 7m records had been created using the platforms. • Poole Emergency Department was almost entirely paperless. • Future plans included: - Further steps towards a paperless Trust - Development of the My Dorset Care Record - Increased applications of Med Tech - Sustainable Technology - Digital services being Dorset Wide The Board NOTED the Digital Transformation Strategy.
BoD 187/21	**Standing Financial Instructions** The Chief Finance Officer presented the Standing Financial Instructions, highlighting the following key points: • The procurement extract had been presented to the Finance & Performance Committee in September 2021, with the full update presented to the October 2021 Audit Committee. • A number of minor formatting updates were made following the annual review, with one substantial change regarding the public procurement regulations – implementing an amendment that came into effect in August 2021. • The amendment approved the reclassification of NHS Foundation Trusts from a Sub Authority to a Central Authority. The Board APPROVED the Standing Financial Instructions.
BoD 188/21	**Board Assurance Framework: Six Monthly Review** The Chief Nursing Officer presented the six month review of the Board Assurance Framework, highlighting the following key points: • Risks related to achieving the Trust's objectives had increased. • Some risks had also reduced, the details of which could be found in

	the report. • Mitigating actions were in place for each risk and were carefully reviewed through the Trust's governance structures. The Board was ASSURED by the six month review of the Board Assurance Framework.
BoD 189/21	**7 Day Services Audit Compliance** The Chief Medical Officer presented the 7 Day Services Audit Compliance, highlighting the following key points: • There had not been an annual audit against 7 day service standards for the previous two years as a result of Covid. • The Trust had fed back to national consultation and had put forward challenges regarding 7 day standards for senior clinicians, same day emergency care and medically ready to leave patients. • The Trust would be expected to recommit to these standards in early 2022. The Board NOTED the 7 Day Services Audit Compliance.
BoD 190/21	**Enabling Accountability Framework** The Chief Operating Officer presented the Enabling Accountability Framework, highlighting the following key points: • The previous framework had been agreed in August 2020 and that it would be reviewed 12-months post-merger. • The framework included mechanisms, processes and lines of accountability to monitor and escalate performance. • The document had been presented to the September 2021 Trust Management Group and November 2021 Finance & Performance Committee. • The Finance & Performance Committee had suggested the inclusion of a paragraph on personal accountability. A Non-Executive Director questioned whether the Board was doing enough to scrutinise clinical effectiveness, as detailed in the framework. The Chief Nursing Officer, to clarify this point, suggested adding that the Board was responsible for overseeing the governance framework to enable appropriate scrutiny. The Chief Finance Officer made the Board aware of a further amendment from the Finance & Performance Committee. This was the expansion of paragraph 6.1.13 to reference more fully the oversight through the Charitable Funds Committee. It was also noted that the document included the financial management accountability framework. The Trust was not operating against this framework due to the national interim financial arrangements. This would be reviewed as part of the annual planning for next year. The Board APPROVED the Enabling Accountability Framework, subject to the above amendments.

BoD 191/21	**Board of Directors: Committee Terms of Reference** The Company Secretary presented the Terms of Reference and Governance Map. **Audit Committee Terms of Reference:** The Committee APPROVED the Terms of Reference. **Charitable Funds Committee Terms of Reference:** The Committee APPROVED the Terms of Reference. **Finance & Performance Committee Terms of Reference:** The Committee APPROVED the Terms of Reference. **Quality Committee Terms of Reference:** The Committee APPROVED the Terms of Reference. **Workforce Strategy Committee Terms of Reference:** The Committee APPROVED the Terms of Reference. **Governance Map:** The Committee APPROVED the Governance Map.
BoD 192/21	**Questions from the Council of Governors and Public** The Chief Finance Officer introduced a multi-part question, submitted in advance of the meeting, from a member of the public. The member of the public was present during the meeting and was the given the opportunity to respond to the Chief Finance Officer • *Is the Trust prepared to leave the Stonewall scheme following the withdrawal of the Department of Health?* The Chief Finance Officer affirmed that all of the Trust's memberships, including Stonewall, were reviewed on a regular basis. Any review of Stonewall would be undertaken in consultation with the staff networks, particularly the LGBTQ+ staff network, to ensure that an informed decision was made, consistent with the Trust's values. • *Is it appropriate for the Trust to be signing up to another Stonewall backed benchmarking scheme?* The Chief Finance Officer responded that NHSE had recently commissioned a collaboration of partners, including Stonewall, to deliver phase two of the NHS Rainbow Badge scheme. This allowed Trusts to demonstrate their commitment to reducing barriers to healthcare for LGBTQ+ patients. The Board wished to draw upon any support to tackle health inequalities and promote inclusion. Therefore the Trust was keen to engage with the new scheme as it was promoted. • *Is there a conflict for the Trust and the wider NHS to remain with Stonewall whilst trying to deliver the new single-sex ward policy?* The Chief Finance Officer emphasised that the membership with Stonewall was just one source of advice and that the Trust received guidance from a

	large number of organisations. As such, the Trust did not believe that there was a conflict. The Trust had taken expert legal advice when reviewing policies, particularly the recently updated Single-Sex Accommodation policy and Privacy & Dignity policy in order for the policies to remain compliant with relevant legislation and the appropriate legal precedent. Staff, patients and members of the public were all involved in the development of the policies. The Chair introduced questions, submitted in advance of the meeting, from Diane Smelt, Public Governor: • *Would it be possible to extend thanks to the members of staff involved in the Covid booster vaccine service?* The Chair advised that the Board would be very happy to do this and this was echoed by the Associate Director of Communications. • *Further details were requested regarding the outsourcing of ultrasound services.* The Chief Operating Officer explained that the Trust performed 3,000 non-obstetric and 2,700 obstetric ultrasounds per month. As a commitment to improving diagnostic waiting times, 325 ultrasounds per month were transferred into the private sector. The organisation that the patients were sent to was a training centre for sonographers and the Trust was very happy with the provider. Only GP ultrasounds were outsourced to this provider and this had no impact on deep vein thrombosis (DVT).
BoD 193/21	**Any Other Business** The Chair made the following points prior to the close of the meeting: • A new Governor, Richard Ferns, had started on the 1st November 2021. • The Board extended it's thanks to Christine Hallett, Non-Executive Director and the Company Secretary following their final public Board meeting.
	The date and time of the next Board of Directors Part 1 Meeting was announced as Wednesday 26 January 2022 at 13:15 via Microsoft Teams.

MATTERS ARISING: ACTION TRACKER PART 1 BOARD OF DIRECTORS JANUARY 2022

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Status
November 2021	BoD 177/21	**Covid Outbreak Report:** To present the Covid Outbreak Report to the January 2022 Board of Directors meeting.	PS	January 2022	An item on the January 2022 BoD agenda
November 2021	BoD 178/21	**Quality Impact Assessment:** To present the updated Quality Impact Assessment policy to the January 2022 Board of Directors meeting.	PS	March 2022	Deferred from January to March 2022 meeting
November 2021	BoD 181/21	**Safeguarding:** To circulate the Safeguarding Statement of Compliance to members of the Board of Directors.	PS	January 2022	Sent to Board 18/01/2022
November 2021	BoD 183/21	**Infection Prevention & Control:** To circulate the Infection Prevention & Control Statement of Commitment to members of the Board of Directors.	PS	January 2022	Sent to Board 18/01/2022

Key:	Outstanding	In Progress	Complete	Future Action

Chief Executive Report
January 2022

1. Managing over the Christmas/New Year Period

In starting the new year, I would like to take this opportunity to thank all our staff and operational teams for doing such an excellent job over the Christmas/New Year period. As everyone knows, this is always a busy time, and we knew that it would be exceptionally challenging given the emergence of the new omicron variant. An enormous amount of planning and preparation took place in advance of the holiday period to ensure that we were able to maximise our available capacity, and despite increasing staff sickness rates, we were able to maintain emergency and urgent care services through the dedication, commitment and flexibility of all our UHD staff.

I should also like to thank all our Dorset partners for their support in both the lead up to Christmas and over the holiday period as we have worked hard together to avoid unnecessary admission, ensure the swift discharge of our patients, and maintain flow throughout the hospital. Whilst this continues to be very challenging, we know that colleagues in our partner organisations have been working to support us, and this is much appreciated.

2. Covid-19 update

At the time of writing, Covid-19 cases in both the BCP Council and the Dorset Council have increased significantly compared to previous reports - now standing at 1350.7 and 1159.3 per 100,000 respectively. The rates are lower than the England average, which is currently 1695.4 per 100,000, but BCP is higher than the average for the South West region (1270.2).

Our hospitals are currently treating 63 Covid-19 positive patients, with 6 receiving critical care – although it is important to note that our Intensive Care Units have been full and extremely busy with other non-covid patients. This situation has been extremely challenging for our ICU and operational teams to manage for several weeks now.

The Trust has been working hard with its partners to ensure that we have plans in place to manage a very significant surge in cases. At the time of writing, we are still expecting the numbers to increase, based on experience from London and the rest of the country. However, the modelling suggests that any surge in admissions should pass more swiftly than in previous years. Feedback from elsewhere suggests that the impact on hospitals is less severe than previously, with fewer patients needing admission, fewer needing admission to ICU, and most patients staying in hospital for a shorter period. Of course, the successful roll out of the vaccine has made an enormous difference to the impact of Covid-19 on hospital services – recognising that those people who have not been vaccinated can still become very ill indeed.

Of particular concern this year is that we are seeing more staff absence related to covid, and this of course can result in very significant disruption to services.

As the pressure has continued to build, the Trust has had to cancel increasing numbers of routine planned operations, to free up capacity and enable staff to be safely redeployed. It is hugely disappointing to have to take this action, and we fully recognise the impact on those individual patients waiting for treatment. However, our priority has to be to maintain safe care, and this inevitably means reducing our elective work.

Clearly, it is important that we continue to prioritise supporting our staff - and I am grateful to all those who have been actively listening to staff, ensuring that action is taken in response to their concerns. This has been a very high priority for our culture champions, our

organisational development team and of course, our frontline managers. Over the past eighteen months, the Trust has developed a broad range of initiatives aimed at supporting the health and wellbeing of staff, and this continues to be very important. In addition, in recent weeks, we have been focusing even more on tackling some of the practical issues that have been raised by our teams - for example, we recently trialled a 'Hot Food at Night' initiative, whereby catering vans were onsite at both our RBH and Poole sites providing subsidised meals for our night-shift workers. All senior leaders and line managers continue to connect closely with their teams, making sure that good communications are maintained and that issues are addressed as they arise.

One of the issues that has been the subject of much discussion recently is of course the national policy relating to the vaccination of staff. The Government announced last year that healthcare workers in frontline and patient-facing roles should have had both the first and second doses of the Covid-19 vaccine from this April. This is to protect both our patients and other NHS staff. Within UHD, at the time of the last review of the data, 89.2% of staff had received both the 1st and 2nd doses, whilst 79.7% of staff had had the booster. These figures are expected to increase over the next few weeks.

We are working with those who have not yet had the vaccine, to understand the reasons and see if we can address any concerns. This is clearly a very important matter, and we are doing everything we can to support staff in getting all the information that they need, and enabling them to access the vaccine swiftly.

Meanwhile, members will be aware that for some time, one of the biggest concerns for the Trust has been the high number of patients within our hospitals who are medically fit for discharge and no longer need acute care. A large number of hospitals across the country are in a similar position, and as such, this issue has been receiving a great deal of national attention. New national guidance has recently been published, emphasising the need for safe, swift discharge from hospital; there has also been a national audit this month of the number of patients in acute hospitals who do not meet the criteria to reside.

At the time of writing, 215 people that do not meet the criteria to reside remain in one of our hospitals - approximately 20% of our total bed capacity. This situation has come about for a number of reasons but is mainly due to pressures within the social care sector, which is currently experiencing its own significant workforce challenges. As highlighted in earlier reports, this is very much a priority for the Dorset system, and we are working hard with our partners on a range of initiatives aimed at increasing capacity in the community - including the development of a new "Care Hotel" facility. A system-wide group has been working to develop this concept, taking account of the learning from elsewhere in places such as Devon and Cornwall, with representatives of UHD playing a very active part in taking this forward. I am pleased to confirm that a new facility will be opening this month, which will mean that 18 additional beds will be made available within a local hotel. These will be pivotal in freeing up capacity within our hospitals.

Although the Trust is clearly under significant pressure, it is important to note that we are in a much better position than this time last year. We have all learned a great deal about the Covid-19 virus and we have invested a great deal in new equipment and facilities that enable us to provide better care. We have much better access to testing, there are new treatments available, and we have more robust arrangements in place to prevent the spread of covid infection. All this – coupled with the innovation that we have seen over the past year in response to the pandemic - means that we are now far better placed to respond to the anticipated surge.

Finally, it is important to note that once this surge has passed, UHD will be redoubling its efforts to get our elective patients treated swiftly. We shall keep building on our learning so that we come out of the pandemic with better, stronger services – ones that better meet the needs of our patients, provide a better patient experience, and use our resources to very best effect.

3. New Chief Executive appointmented – Siobhan Harrington

From the announcements made earlier in the year, members will be aware that I shall be retiring at the end of March 2022, which means that University Hospitals Dorset will soon have a new chief executive.

Siobhan Harrington, currently chief executive for Whittington Health NHS Trust in London has now been appointed into this role and will be joining the Trust as Chief Executive on 1 June 2022. Siobhan began her career as a nurse in London, working at St Thomas's and the Royal Free Hospitals. She was appointed director of Primary Care Commissioning and lead nurse for Haringey PCT in 2004, before joining the Whittington Hospital in 2006. Since then, she has held a number of senior roles within that organisation including two years as programme director for the Barnet Enfield Haringey clinical strategy. Siobhan has been chief executive of Whittington Health NHS Trust since 2017.

There will be a short gap between my leaving and Siobhan arriving, and over this period (1st April to 31st May), Paula Shobbrook, Deputy Chief Executive and Chief Nursing Officer will be Acting Chief Executive for the Trust.

We are all delighted that Siobhan will be joining UHD and with her background and experience, she is clearly very well-placed to take forward our challenging transformation and integration agenda.

In the meantime, members can be assured that over the next few months, I shall be working closely with both Paula and Siobhan to ensure a smooth transition to the new arrangements.

4. David Moss Stepping Down

Another important announcement was made earlier this month, in that our Chairman, David Moss has decided to step down at the end of March 2022. David joined the NHS in 1973 as Deputy Director of Finance at St Thomas's Hospital London, and since then, has had extensive experience within the NHS – working at both a national and local level, in both an executive and a non-executive capacity.

David was formerly Chairman of both The Royal Bournemouth and Christchurch Hospitals and Poole Hospital NHS Foundation Trusts before being appointed as the first Chairman of UHD in October 2020. He has therefore overseen the merger of the trusts, the successful appointment of myself as its first Chief Executive, and more recently, the appointment of my successor, Siobhan Harrington. David has played a critical role over the past few years in leading the Board of Directors and helping to steer the Trust through the recent Covid-19 pandemic. Throughout this time, he has continued to champion system working, along with the development of the Dorset Integrated Care System (ICS).

The process of recruiting a replacement for David is already underway and it is anticipated that a new Chairman will soon be appointed. Philip Green, Vice Chairman for UHD will take on the role of acting Chair of the Trust Board and of the Council of Governors from 1 April 2022, if the new Chairman is not in post by then.

There will be another opportunity to say goodbye to David at our Board meeting in March. However, I wanted to take this opportunity to highlight this development and thank David for all his dedicated service to the NHS – and in particular, to UHD.

5. 2022/23 Priorities and Operational Planning Guidance

On 24 December 2021, NHSEI released its operational planning guidance for 2022/23, including its ten priorities for the service. The guidance signals delayed implementation of the integrated care systems (ICS) from 1 April 2022 to 1 July 2022, due to parliamentary

timings, although ICS development work will continue as a priority during this extended transition period.

The planning timetable has been extended to the end of April 2022, with systems and providers asked to submit draft plans by mid-March. The deadline date for the submission of final plans will be kept under review, with further detailed guidance published in due course.

The priorities set out in the planning guidance are based on Covid-19 activity and with the expectation that disruption returns to 2021 level by early summer.

A UHD Planning Group has been introduced to establish planning assumptions, triangulate data, and develop the narrative document that will underpin our organisation's approach. Our plans will of course be linked to our Board Objectives (which are to be refreshed) as well as the Board Assurance Framework, so that our Annual Plan delivers our over-arching strategic objectives.

Ten national priorities have been identified, and all systems are being asked to develop plans that will ensure their delivery:

- Investing in the workforce and strengthening a compassionate and inclusive culture
- Delivering the NHS COVID-19 vaccination programme
- Tackling the elective backlog
- Improving the responsiveness of urgent and emergency care and community care
- Improving timely access to primary care
- Improving mental health services and services for people with a learning disability and/or autistic people
- Developing the approach to population health management, with a view to preventing ill-health, and addressing health inequalities
- Exploiting the potential of digital technologies
- Moving back to and beyond pre-pandemic levels of productivity
- Establishing ICBs and enabling collaborative system working

Partners across the Dorset system will work together to take these priorities into account in developing the system plan, which will of course interconnect with the plans of the individual organisations.

6. Integrated Care System (ICS) Developments

Work is continuing across Dorset to further develop our Dorset Integrated Care System (ICS). In November, it was announced that Patricia Miller had been appointed as the Chief Executive designate for the new Dorset Integrated Care Board (ICB), and it has since been agreed that Patricia will take up this role from 1 February 2022. Work is now underway to firm up the structure and composition of the new ICS Executive team in line with national guidance, with consultation taking place with those affected by this change.

Meanwhile, partners in Dorset have developed a draft ICB Constitution, based on the national model, which will be discussed with NHSE/I later this month.

Colleagues from across Dorset (including Public Health Dorset) have been working to develop a draft proposal for the co-design and co-creation of the new Dorset Integrated Care Partnership (ICP) Strategy, which will define our shared priorities and shape our work programmes going forward. The proposal was shared with the System Partnership Board on 16 December 2021.

Partners continue to discuss the most appropriate arrangements for a new Provider Collaborative in Dorset in line with national guidance, as a means of further joining up services, tackling variation and making best use of resources.

Similarly, further engagement has been taking place amongst members of the two local Health and Well-being Boards (one within BCP Council and one within Dorset Council) to seek views on the proposed "Place-Based" Partnership model. This work will assist partners within the Dorset system in firming up the design of new governance arrangements that will allow for greater focus on "place" within the Dorset system.

All partners were encouraged to note that funds have been made available from NHSI/E to enable the development of a Citizen's Panel for the ICS, that will be able to reach out to diverse communities and areas of inequalities. The Panel will be a key enabler for all system partners to collectively and continuously listen and act on the experience and aspirations of local people and communities.

Engagement work will commence this work on a new People and Community Strategy for the ICS, involving all system partners plus representatives of the Voluntary, Community and Social Enterprise (VCSE) sector.

The overall programme to establish the strengthened ICS is currently on track, but clearly, with the revised go-live date, there will be some delay before the new arrangements are formally in place.

7. Estates Transformation Programme

Members will recall that our Trust received Treasury approval to the STP Wave 1 business case for £201.8m at the end of 2021 and the team continues to make excellent progress on both the Royal Bournemouth and Poole Hospital sites.

At the time of writing, the steel frame for the Poole Theatres has just completed and with that, the risks to the Trust associated with demolition and ground works have now passed. We continue to make excellent progress and the concrete planks will be installed through January and February. We are looking to hold a "Topping Out" Ceremony (a traditional ceremony held when you reach the highest point in the building) which we hope will be able to take place towards the end of May 2022.

On the Royal Bournemouth site, the demolition phase has been completed and the Piling work continues at great pace in order for it to be finished by the end of this month. Visitors will have noticed that all the final road changes are now complete and the road around the hospital is now in its final layout until the completion of the building works in 2024. Members who have visited the site will also have noticed that the Energy Centre frame (near the Outpatients entrance) and the staff welfare for the Contractors has also been completed. The Trust continues to actively manage the risk and contingency across the entire scheme, escalating any issues to the Reconfiguration Steering Group and the wider Trust Board as necessary.

Elsewhere on the Royal Bournemouth site the new modular Derwent theatre installation was completed earlier this month, and the ground clearing has commenced in Wessex Fields that will enable the development of the new Pathology Hub.

Finally, I am delighted to confirm that through close and effective working with the New Hospitals Programme (NHP) team, the Trust has been able to secure the necessary design fees that will allow us to continue progressing at pace.

Overall, I am very pleased and proud with all the progress that continues to be made with our estates transformation programme. The Transformation Committee and associated Groups continue to oversee this work, with key risks and decisions escalated as appropriate.

8. Good News

Welcome to our Students

We are delighted to extend a warm welcome to 76 first-year student nurses who have started a placement at our hospitals, alongside our first-year student nurse apprentices who joined us in October 2021. Many of these students first encountered Covid-19 whilst still at school or college and have now bravely stepped forward to join the nursing profession and the NHS at a time of great need. These students join us from Bournemouth University showing us once again the value and importance of our partnership.

We have also welcomed an array of students from other professions, including student midwives, nursing associates, physician associates, physiotherapists, occupational therapists, dieticians, speech and language therapists, operating department practitioners, paramedics, healthcare scientists, pharmacy technicians, medical students, and many more allied health professionals. Learning and improvement are very highly valued within our organisation and each one of these individuals is very warmly welcomed to the Trust.

Opening of the Outpatient Assessment clinic

From the very extensive media coverage that we have seen in recent weeks, members will be aware of the exciting launch in December 2021 of our brand new outpatient assessment clinic in the Dolphin Centre in Poole. This purpose-built facility is on the top floor of Beales Department store and will play a vital part in tackling waiting times within a large number of specialties, including breast screening.

Playing our part in the global fight against Covid-19

UHD is very proud to have played a part in helping identify six Covid-19 vaccines that are safe and boost immunity for people who have had two doses of AstraZeneca or Pfizer-BioNTech in a UK-wide COV-BOOST trial.

The world-first study, which recruited volunteers at the Dorset Research Hub based at UHD, was key to shaping the UK booster programme and gives vital evidence for global vaccination efforts. Results from the study, led by University Hospital Southampton, were published in The Lancet in December 2021 – another example of UHD's commitment to research and excellence.

Debbie Fleming
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 26 January 2022

Agenda item: 7.2

Subject:	University Hospitals Dorset (UHD) NHS Foundation Trust Integrated Performance Report (IPR) December 2021

Prepared by:	Executive Directors, Alex Lister, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Irene Mardon, 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 December 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. The operational planning guidance (outlining the priorities for the year ahead) are detailed below: **Systems are being asked to deliver on the following ten priorities in 22/23:** A. Investing in the workforce and strengthening a compassionate and inclusive culture B. Delivering the NHS COVID-19 vaccination programme C. Tackling the elective backlog D. Improving the responsiveness of urgent and emergency care and community care E. Improving timely access to primary care F. Improving mental health services and services for people with a learning disability and/or autistic people G. Developing approach to population health management, prevent ill-health, and address health inequalities H. Exploiting the potential of digital technologies I. Moving back to and beyond pre-pandemic levels of productivity J. Establishing ICBs and enabling collaborative system working
Key points for Board members:	**Areas of Board Focus** High Bed occupancy levels. Current Ambulance handover delays and the amount of time patients are spending in the emergency department. Continuing challenges with 'No Reason to Reside' (NRTR) and the increase in bed pressure, with the number of Covid is contributing to maintain a high bed occupancy across the organisation. Impact on reduced hospital flow

has the potential to impact on patient safety, experience and increased cancellations. Workforce availability to meet escalating capacity levels, that driving increased agency costs and staff wellbeing. Impact on hospital reputation and increased challenge to elective care recovery as a result of having to more capacity aside for emergency /urgent care response. The impact this may have on the fundamentals of care in particular deconditioning of patients.

Operational Performance

Urgent and Emergency Care – National

The national 10 Point Action Plan for Urgent and Emergency Care has been fully reviewed and workstream action plans under our UEC Quality & Performance Improvement Programme are focusing on the key priorities of the plan. We are also in the process of reviewing internally and with System partners the guidance relating to addressing Ambulance Handover Delays to consider further actions required. Our ongoing escalation beds, enhanced Same Day Emergency Care (SDEC) Services and discharge pathway work will also be key. The organisation has now received additional support through ECIST with 5 initial key areas of focus shared with the teams. The programme forms part of the enhanced support for the emergency departments triggered through the Trust accountability framework.

Emergency Care @ UHD

UHD continues to experience significant challenges with its emergency flow. All ED attendances remain 2.8% (YTD) above those reported in same period in 2019/20.

Daily Ambulance activity is similar to November but lower than the same period in 2019 (c30 per day as an average). Ambulance delays were consistent with November with 164 waiting over 60 minutes (175 November). The Trust have been advised by SWAST that in in with national guidance Ambulance crews will no longer support 'cohorting' patients in corridors from January 11th, and the implications of this are being worked through including staffing cohort areas.

Emergency Departments

The IPR provides the detailed performance against the new national Urgent & Emergency Care standards. Headlines include:

- Ambulance conveyances are YTD 0.4% below those observed same period in 2019/20, and YTD ED attendances are 2.8% above 2019/20.
- ED mean time on both sites declined and remains significantly above the national indicated standard
- There were 34 x 12 hour waits from Decision to Admit (DTA) an increase in month compared to October (+13 breaches)

(colours based on change from last month)

		Dec-21		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	298	304	301
Time to Initial Assessment	15 mins	6	3	4
12 Hour ED Waits	0	215	203	418
Internal Care Standards				
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	112	159	137
Mean Clinically Ready To Proceed to Left Dept	60 mins	243	122	177

The work and support from ECIST will be presented to the Trust

Management Group in early January for review of the opportunities with all directorates and to agree the priorities and associated governance. There is a clear message that a high number of patients could be effectively seen in an alternative setting, both within UHD and in Primary care..

The above pressures continue to reflect a regional and national picture and there is ongoing concern across the Dorset and National Systems that this trend will continue.

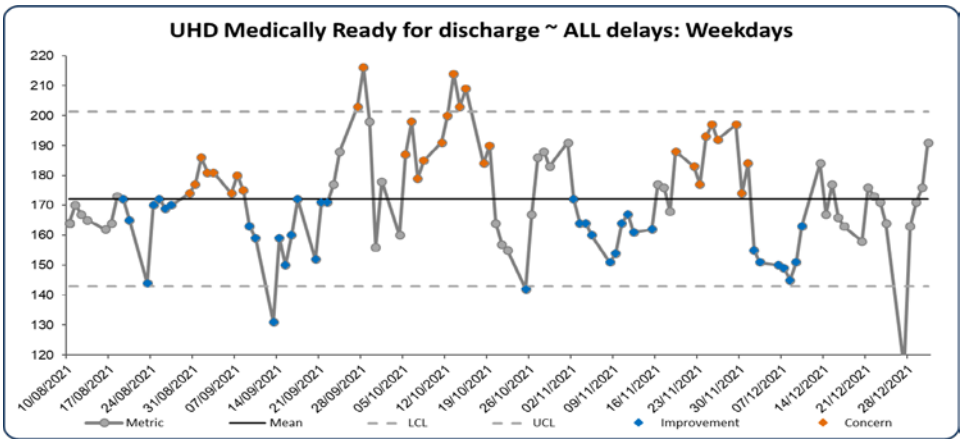
Occupancy, Flow and Discharge

Both sites continued to have all escalation beds open in December alongside the majority of infection control closed beds using robust risk assessment and mitigation plans to ensure we optimally offset risks. However, despite this, occupancy remained high at 91.3%.

The number of patients ready to leave with No Reason to Reside (NRTR) decreased in month (average of 8 patients). Occupied bed days also marginally decreased for patients with a longer length of stay (7/14/21+). The latter continues to exceed the national standards as a proportion of all inpatients.

Externally we continue to work with partners on the Home First programme developing several initiatives to manage the increasing discharge challenges. The introduction of block booked beds, commissioning of the Care Home Selection Service (CHS) and domiciliary rapid response initiatives have positively impacted the position in December.

Further strategies are being adopted to manage the emerging pressures including introduction of Care Hotels and enquiries with specific care homes to support Omicron surge plans into January as a designated Covid settings.



For the period August to date, 'special cause – concern' was witnessed in November with a small measure of improvement in the first week of December with a reduction in delays to an average of 166 per day. Internal delays also improved during this period. As the Covid position continues with significant concerns raised through the Epicell modelling it is imperative that the improvement work and decant plans continue in readiness for a predicted surge and the impact this may have on the hospitals and individual patients. Additional extremis surge plans have been developed to provide assurance that the Trust can manage the predicted surge in January, noting the operational pressures of safely staffing extended capacity.

Surge, Escalation and Operational Planning
At the time of writing, we have 75 confirmed Covid inpatients, below the levels experienced in Wave 2 (January/February) but above the 5% national planning requirements. This has resulted in additional covid inpatient capacity being operationally required and has reduced the availability of 'green' (non Covid) elective and non-elective capacity. This has had a negative impact on flow throughout the hospital and directly on ED and Critical Care Units. Further initiatives/capacity has had to be developed to manage the predicted Omicron surge; teams are working across the Dorset system to align plans.

Referral to Treatment (RTT)

92% of all patients should wait no more than 18 weeks for treatment

	Nov 21	**Dec 21**	
Referral to treatment 18 week performance	**64.0%**	**61.6%**	**Target 92%**
104 weeks	248	273	**Target 0 by March 22**
Hold or reduce >52+ weeks compared to Sept 21	3,322	2,968	**-512 v Sept 21**
Stabilise Waiting List size compared to Sept 21	52,383	52,972	**+1,481 v Sept 21**

H2 Requirements

- Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer (Patients codes P6 on the national prioritization coding).
- Hold or where possible reduce the number of patients waiting over 52 weeks.
- Stabilise the waiting list to the level seen at end of September 2021.

Factors impacting on the RTT standard
The high number of RTT waits over 52 weeks is mainly due to a reduction in theatre/treatment and outpatient capacity during the pandemic in 2020-21. An improving and reducing monthly trajectory continues in line with the trust's operational plan for 2021/22. A reducing proportion of these are waits over 78 weeks, however the number waits over 104 weeks has increased marginally (+25) in December 21.

The Trust is currently working to a national ambition to eradicate 104 week waits by March 2022. As noted above the requirements for additional Covid inpatient capacity has reduced the availability of 'green' (non Covid) elective capacity in December which has impacted on the 104 week wait recovery plan. Overall patient cancellations in outpatients were also high in December, increasing to 7.1% (an increase of 2.2% on last month).

High level elective care recovery actions include:

- ***Ongoing clinically led waiting list validation*** A digitally enabled validation programme is also live in ENT, OMF, Orthopaedics, General Surgery, Gynaecology, and Cardiology, with Neurology also having commenced in December 2021.
- ***Further expansion and improved utilisation of additional internal or insourcing and outsourcing capacity*** to
- ***A High flow clinical assessment facility at Dorset Health Village***

- ***Continuing to promote use of digital technology***
- ***Increased use of Patient Initiated Follow Ups and Advice and Guidance***
- ***Delivery of capital transformation through initiatives under the Targeted Investment Fund to support elective recovery.***
- ***Two organisational-wide improvement programmes:***
    a. Theatre improvement programme: value and efficiency
    b. Outpatient Enabling Excellence and Transformation programme

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

November	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	11220	9,614	1606	**14.3%**

The DM01 standard has achieved 85.7% of all patients being seen within 6 weeks of referral, 14.3% of diagnostic patients seen >6weeks.

High level diagnostic recovery actions include:
- Continuation of additional temporary endoscopy capacity
- 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
- Additional MRI capacity brought online

Cancer Standards

	Measure	Target	Q4 20/21 - FINAL	Q1 21/22 - FINAL	Q2 21/22 - FINAL	Nov 21 - FINAL
UHD	Cancer Plan 62 Day Standard (Tumour)	85%	77.8%	79.1%	76.9%	71.4%
	62 Day Screening Standard (Tumour)	90%	88.1%	88.1%	81.0%	84.0%
	31 Day First Treatment (Tumour)	96%	96.7%	97.1%	97.4%	96.8%
	Subsequent Treatment - Surgery	94%	90.5%	91.2%	92.2%	95.5%
	Subsequent Treatment - Radiotherapy	94%	99.0%	99.0%	97.8%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	99.7%	98.8%	98.1%	100.0%
	Faster Diagnosis	75%	79.1%	76.5%	75.4%	66.4%
	Over 104 days (treated in month)	N/A	16.5	30	28	15

The Trust continued to receive a significant increase in referral numbers in November (16% increase compared to same period last year) and a 14% increase against the planned trajectory. The tumour sites seeing the highest increases were colorectal (30%), lung (24%), skin (27%), and hematology (39%). The number of patients on a fast track pathway continued to challenge all performance standards.

Performance against the 28-day faster diagnosis standard in November fell to below the 75% threshold, reporting 66.4%. First OPA capacity was the main breach reason (56%). Sites that are most challenged are breast, colorectal, gynae and urology.

The Trust has consistently achieved the 31-day standard between April – November 2021 and is also expected to be achieved in December. The Trust also achieved 2 out of the 3 subsequent treatment KPI's in November with similar performance expected in December. The 62-day performance was below the 85% threshold (71.4%), this is above the current national average of 68.3%.

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. • Delays in histopathology reporting turnaround times, mainly affecting patients on a pathway at Poole Hospital. • Workforce capacity to manage the large 2 week wait volume

High level actions include:

- Pathway analysis supported by Wessex cancer alliance to identify opportunities - to maximise capacity and improve flexibility - initially focusing on lung and head and neck. Wessex Cancer Alliance have agreed to fund an intensive 12 week cancer improvement programme which aims to commence in January 2022.
- Commencing work to move towards a Dorset wide cancer PTL as per National guidance, looking to incorporate the use of existing IT (DiiS)
- One stop opportunities at the start of the pathway to improve time to diagnosis- sarcoma/ lump clinic and neck lumps

Health Inequalities

The Trust continues to support work to tackle health inequalities through the Dorset ICS Health Inequalities in Elective Care Programme. The programme is in the intervention design stage for two cohorts of patients waiting elective care i) People waiting times > 18 weeks and from deprived communities ii) People on Orthopaedic waiting lists. Currently a process of re-identification of patients to identify named patients in these cohorts is taking place. Patients in these cohorts will then be contacted to support them to access community services that will enable them to wait well. For example, community groups, exercise and weight loss programmes, support with shopping or transport or stop smoking services/advice.

Quality, Safety, & Patient Experience

Infection Prevention and Control:

- Covid19 outbreak report now finalised and an action plan sent to the CCG.
- Community cases of COVID-19 in December increased, translating to an increase in hospital admissions and increase into Critical care admissions.
- Outbreaks have been reported within Wards on both sites.
- The impact of the new variant, Omicron is being felt but the majority of admissions for this remain (>40%) in the London area hospitals.
- MRSA - 1 HA case reported this year, 2 CA cases reported. This is in line with previous trends. The Post Infection Review for the HA case did not identify actions for the Trust.
- MSSA and E.coli now have additional case definitions that include community cases with previous hospital admission (last 28 days) so comparison to the previous year is not possible by these number. However, we do know that MSSA blood stream infections

	are increasing within UHD and across the South West - within UHD the case rate has increased over the past 1 year from 10/100k bed days to 17/100K bed days. A collaborative project looking at MSSA has commenced within Dorset. Themes identified within the PIR for these cases point towards poorly maintained vascular access devices and poor skin integrity being a common factor in bacteraemia, there may be some benefit in looking at skin decolonisation for high risk patients. It is an aim of the team to look at this within the business plan. Hospital associated E.coli blood stream infections remain steady however the ambition set out by NHS Improvement to reduce these and other gram -ve infection has not proven to be successful. • Case of Clostridioides Difficile have increased for those patients with a hospital onset and community onset healthcare associated infection in conjunction with this, the frequency of relapse and the severity of cases has also increased. This is a common trend across the South West, an ongoing collaborative project across the region is gathering data to help us to understand the reasons behind this increase. However, our rates per 100K admissions is below the England rate (36 vis 45 per 100K). Current themes from Post Infection Review indicate the challenge of ensuring prompt identification, sampling and isolation of patients is a key factor to improve upon. **Clinical Practice Team:** **Moving & Handling** • Inability to meet M&H training demands for UHD remains as 12 on the Risk Register. Level 2 essential core skills training has continued to be delivered during the periods of Trust escalation. • Notified that approx 30 pieces of M&H equipment (hoists/stand aids) on the Poole site have been classed as obsolete by the manufacturer. This means they are no longer supported by replacement parts and have lapsed into being considered as uneconomical for repair. With support from Estates we are drafting a risk register entry supported by an SBAR. Equipment has been checked and is safe for use at present. Moving & handling equipment provision and subsequent testing is regulated under the PUWER and LOLER statutory regulations. **Falls prevention & management** • We continue to see peaks in the number of falls being reported resulting in no or minor patient harm. On investigation staffing and our inconsistent ability to provide enhanced care requirements are contributing factors. **Tissue Viability** • We have successfully recruited into the vacant Band 6 Tissue Viability Nurse post and we look forward to welcoming a colleague from the community in April. • The team continue to work through standardising and refining processes. Cross site working is now an established routine and we can now adopt a more flexible approach supporting the site with the greatest clinical need on a daily basis. The Clinical Practice Team have also been supporting ward teams when staffing has been challenging across both sites.

Patient Experience:

Friends & Family Test

- Across our sites, we received 3,585 FFT responses this month and overall, 91% of patients who responded rated their care as good or very good. This is an improving trend for the third consecutive month.
- The highest number of responses (1182) came from our outpatient services, with the general outpatient departments on both main sites achieving 95% good/very good feedback ratings.

'Very caring, listened and made me feel at ease, the doctor and the lady that accompanied her were both great'
'Thoroughly professional, punctual, kind service, thanks'.
'Thorough, took time and empathy was clearly a factor…..ably assisted by her support staff and it was a team effort…This was a very special interaction'.
'Understanding and listened to everything I had to say. They have been very helpful and given me hope that whatever is going on they will try to help me….Thank you to all the staff working hard at this difficult time'.

PALS and Complaints

Trust records show that 27 complaints were received during December. However, this is only part of the picture. During the last two months, the patient experience team have focused on promoting early resolution of complaints as an integral part of the new UHD complaints model. However, due to gaps in the workforce, some of this data has not been accurately recorded and this may account for the lower numbers. This data will be corrected for next month.

The number of complaints responded to in month has significantly improved over the last four months, with a total of 58 complaint responses sent out this month. This has reduced the backlog of complaints, primarily caused by significant gaps in the PALS and complaints workforce. Plans remain in place to continue to drive the backlog down to more reasonable levels.

Key themes from PALS and complaints

- Long waits in ED
- Lack of communication and inability to get through to wards and departments by phone
- Poor staff attitude

Workforce

YTD Indicators to December 2021:

		21/22 YTD	20/21 YTD	Variance
Turnover		12.0%	12.3%	-0.3%
Vacancy		5.2%		N/A
Sickness Rate		5.0%	4.5%	0.5%
Appraisals	Values Based	34.5%	42.1%	-7.6%
	Medical & Dental	57.3%	54.6%	2.7%
Statutory and Mandatory Training		87.3%	86.7%	0.6%

December indicators:

		Actual this month	Variance on last month
Turnover		12.8%	0.2%
Vacancy		5.0%	0.4%
Sickness Rate		6.6%	0.7%
Covid-absence non-sickness		0.4%	0.0%
Appraisals	Values based	58.4%	0.2%
	Medical & Dental	54.0%	-9.1%
Statutory and Mandatory		86.2%	0.4%

Month	Sickness Covid	Sickness Other	Sickness Total	Other Covid
Oct -21	0.20%	5.56%	**5.76%**	0.60%
Nov - 21	0.20%	5.69%	**5.89%**	0.42%
Dec - 21	0.29%	6.33%	**6.61%**	0.41%

Performance:

UHD turnover has risen slightly to 12.8% actual this month and is tracking at 12.0% year to date.
Vacancy Rate is showing at 5.2%, an increase of 0.4% on last month. This reflects the increase we have seen in the number of staff leaving the trust. Work continues to refine our data analysis and establishment processing.
Overall Sickness Overall Sickness levels have again increased this month noting added pressure felt on the operations across the site and the impact felt from the Omicron variant. Sickness aligned to Covid has seen a rise from 0.20% to 0.29%.
Medical & Dental appraisal levels have fallen by 9% this month, but overall are tracking higher than last year by 2.7%.

Value based appraisal levels are up slightly again this month by 0.2%. but are still tracking low year to date.
Statutory and Mandatory training compliance continues strong despite continuing disruption to training due to operational pressures.
Temporary Staffing: Volume of requests for temporary staffing is high across all staff groups and specialties; fill rates are lower than previous months for Clinical and Health Care support staff

CPO Headlines:

HR Operations

Covid-19 Mandatory Vaccination Regulations
The Operational HR and Occupational Health teams are working closely together to prepare for 1st April 2022, when healthcare staff (whose roles meet the necessary criteria), will need to be fully vaccinated, unless they meet the exemption criteria. Staff with incomplete vaccination records have been contacted and asked to provide evidence of their vaccination status and/or NHS number, which allows us to check their status, and managers asked to hold sensitive and supportive conversations with colleagues, to actively encourage staff to take up the vaccinations. The HR Operational team is also working collaboratively with Infection Control to ensure that the Trust's Covid Staff FAQ's are amended as Government advice changes. Further Government guidance on the handling of staff who choose not to receive full vaccination is expected week commencing 14th January 2022.

The HR Operational team continue to focus on coaching line managers to address lower level employee relations issues through early intervention. Since the introduction of the HR Triage process in December 2021, 11 cases have been referred to HR for formal conduct/performance investigations. These cases have been triaged, which has resulted in 36% of cases being handled outside of the formal investigation process. These have been dealt with swiftly, effectively and in line with Just and Learning Culture Principles.

Occupational Health and Enhanced Wellbeing Service
The Occupational Health team have been heavily immersed in the vaccination programme and in total 3,100 vaccinations were delivered to UHD staff, family, friends and the public from 19th to 24th December 2021.
Increased waits are being experienced with Psychological Support and Counseling referrals and Management and Musculoskeletal referrals due to high demand and staff absence. No delays are being experienced with pre-employment checks due to the service being supported by bank. Vaccinations are still available to staff via the Occupational Health service.

Resourcing
The number of posts being advertised and new joiners across all staff groups, including medical, has been increasing over the year, as detailed in the table below. Applicant numbers are being affected by market conditions, and additional activity at both trust and system level is taking place for international recruitment, Health Care Support Worker (HCSW) initiatives, widening access to NHS roles, digital marketing and national campaigns for hard to fill roles.

Additional work is in progress to support the mandatory vaccination regulations, develop electronic employment contracts, progress Bournemouth University partnership working, together with a review of the trust's recruitment practice for Equality, Diversity & Inclusion actions.

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	A
General Recruitment - Number of Applications	2105	2048	2166	2315	2657	2838	2222	2029	
General Recruitment - Candidates Offered	234	258	229	256	257	247	299	229	
General Recruitment - Adverts Posted	206	263	282	277	295	257	299	345	
General Recruitment - New Joiners to the Trust	61	83	62	90	125	123	129	60	
General Recruitment - Internal Candidates Started	70	105	91	123	121	143	121	90	

Blended Education & Training (BEAT)
International recruitment and simulation training has moved across to BEAT and a Band 2 - 4 clinical skills review is being undertaken at PHT site, and a Health Care Support Worker (HCSW) retention project has now been completed. This is due to be shared with appropriate forums shortly. Work has commenced with the Integrated Care System on a HCSW vocational scholarship.

Workforce Systems:
1969 changes came through the Workforce Systems team in December. This was 209 more than November. These related to an increase in the amount of Fixed Term Contract changes, position moves and hour changes. Terminations were down slightly from 142 in November to 119 in December.

Temporary Workforce:
Workforce supply gaps are at an all-time high and reflect the current national trends across all sectors and specialties; fill rates are lower than previous months for clinical (50%) and Heath Care support staff (34%). We are seeing a significant increase in the number of Medical bank shifts posted with a fill rate of 57% as well as increased demand for administrative and transformation projects. External agencies have been supporting with sourcing of candidates. Staff movements across the system have been necessary and are being monitored regularly to respond to local system pressures.

Finance

The Trust set a breakeven budget for the second half of the year (the 'H2' period to 31 March) supported by the continuation of national top-up funding and funding to cover specific COVID costs. The national financial framework during this period includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. This is accounted for on a monthly basis, reported as a variance against both expenditure and income budgets. The full year deficit budget of £528,000 reflected the shortfall in ERF income received in the H1 planning period however this has now been fully funded through ERF+ resulting in a forecast breakeven position for the financial year ending 31 March 2022.

At the end of December, the Trust is reporting a £45,000 variance ahead of plan due to the phasing of ERF+ funding. Additional expenditure of £11.178 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been matched in full. Within this aggregate position, the Surgical Care Group report an adverse variance of £1.436 million, mainly due to CIP performance, additional medical staffing costs and partially offset by reduced activity particularly within Orthopaedics; the Medical Care Group report an adverse variance of £157,000, mainly due to an over achievement in cardiac private patient income together with the cessation of Bowel Scope and Bowel Cancer screening services; and the Specialties Care Group report a favourable variance of £1.093 million

	principally due to vacancies within Pathology and Pharmacy. Cost savings of £2.869 million have been achieved to date against a target of £5.870 million, representing an under achievement of £3.001 million. Full year savings of £4.241 million have currently been identified of which 80% is non-recurrent. The refreshed H2 budget includes a significant increase in the savings requirement to £10.124 million for the full year, which if not achieved recurrently will result in further and considerable pressure on future years budgets. Currently the Trust is forecasting to deliver a shortfall of £5.884 million and a recurrent shortfall of £9.267 million. 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 requires very careful ongoing management. As at 31 December capital spend is £32.297 million, being £10.814 million behind plan. This largely relates to underspends in the Maternity Children Emergency Centre and the Theatres Programme (STP Wave 1). The Trust is currently holding a consolidated cash balance of £75.376 million, which is fully committed in support of the medium-term strategic reconfiguration programme.
Options and decisions required:	No decisions required
Recommendation:	**Members are asked to note:** • The areas of Board focus for discussion
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 – increased score to 16 **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 1386** – Cancer waits increasing due to increased referrals. **UHD 1276** – Delayed patient care due to delays in surgery for #NOF patients **UHD1447** - Adverse Outcomes for Orthodontic Patients due to COVID restrictions and lack of additional facilities and manpower **UHD1024** - Risks associated with continuity, capacity and staffing during Pandemic Infectious Disease and seasonal flu **UHD1574 -** Lack of Breast screening staff impacting on waiting times **UHD1437** – Loss of IT Service **UHD1592** - Electronic Prescribing and Medicines Administration Project Delay **UHD1599** - Safety checklist process for all interventional procedures (Never Events) **UHD1260** - Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling **UHD1607** - Failure to maintain Hospital standardised mortality **UHD1640** - Fetal Monitoring equipment **UHD1577** - Unsafe Storage (Fire and Infection Control Compliance) – PH **UHD1591** - Information Asset Management **UHD1202** - Medical Staffing Women's Health **UHD1378** - Lack of Electronic results acknowledgement system **UHD1355** - Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Finance & Performance Committee (Operational / Finance Performance)	Jan 2022
Trust Management Group	Jan 2022

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




December 2021

Created January 2022

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	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	ytd	ytd var	trend
SAFE																							
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	11	15	12	15	8	10	6	7	7	91	-17	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	4	6	2	7	1	3	6	1	1	31	-3	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	1	0	1	1	1	6	2	8	2	22	-2	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	1029	752	959	1022	1012	871	1064	888	871	8468	-3672	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	
		MSSA		1	2	3	9	8	4	6	4	3	2	4	5	5	3	3	4	0	29	-8	
		C Diff		7	6	1	3	1	2	9	3	4	8	8	8	5	8	6	6	0	53	14	
		E. coli		3	12	5	8	2	11	3	3	4	4	9	8	10	7	8	7	0	57	9	
EFFECTIVE																							
Mortality	SMR Latest Jan 21	(source Dr Foster)		104.042	97.2055	111.664	113.307	96.5075	171.543	119.6	87.4												
	Patient Deaths	YTD		207	185	265	244	249	469	299	217	165	185	170	232	223	202	222	238	247	1884	6	
	Death Reviews	Number		105	85	124	111	127	207	152	103	78	71	57	78	61	47	13	18	1	424		
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	30	29	33	48	38	19	33	44	36	310	-16	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	12	14	10	26	22	17	13	12	12	138	-7	
CARING																							
	Complaints Received			57	48	51	56	62	53	53	51	60	68	62	52	57	51	39	20	27	436	23	
	Complaint Response in month			57	48	51	48	49	43	59	59	47	26	64	53	55	28	32	39	58	402	14	
	Section 42's			0	2	0	0	0	0	1	0	0	0	5	0	0	7	0	0	2	14	-12	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	90%	89%	89%	86%	86%	87%	87%	89%	91%	88%	-3%	
WELL LED																							
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	35	40	43	44	47	44	49	44	44	49	15	
	Red Flags Raised*			31	47	51	43	73	129	51	28	41	45	56	80	117	105	160	209	35	848	550	
	*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	5.0	5.2	5.0	4.7	4.8	3.3	4.8	-1.6	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	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%	11.50%	12.20%	12.40%	12.10%	12.20%	12.60%	12.81%	12.0%	-0.3%	
	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%	4.9%	5.0%	5.1%	5.2%	5.2%	5.3%	5.0%	0.5%	
	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%	25.7%	35.7%	48.7%	54.5%	58.2%	58.4%	34.5%	-7.6%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	55.4%	52.5%	50.3%	61.0%	62.8%	54.4%	61.1%	63.1%	54.1%	57.3%	2.7%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	87.20%	87.90%	88.20%	88.10%	88.60%	87.70%	86.50%	85.80%	86.18%	87.3%	0.6%	

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	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	ytd	ytd var	trend
RESPONSIVE																							
Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	14	8	9	11	5	3	7	9	5	71	-87	
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	67	72	98	122	65	51	82	45	53	655	-65	
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	65%	62%	62%	57%	55%	56%	55%	53%	58%	57%	-3%	
	**infection eNA assessment went live at RBCH during April 20*	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	70%	66%	66%	61%	58%	59%	58%	56%	58%	62%	-12%	
		MUST		64%	64%	63%	65%	61%	57%	63%	63%	69%	66%	65%	61%	59%	60%	59%	57%	58%	62%	-2%	
		Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	65%	62%	62%	57%	55%	56%	55%	53%	53%	58%	-2%	
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%	65.2%	65.4%	64.1%	64.0%	64.0%	61.6%			
	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	48,687	49,906	51,491	52,787	52,383	52,972			
	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%	9.4%	12.1%	15.7%	18.6%	1.7%	2.9%			
	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	11,085	10,929	11,508	11,600	11,746	12,904			
	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	5,872	5,971	5,922	5,559	5,413	5,374			
	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	3,402	3,408	3,480	3,442	3,322	2,968			
	No. patients waiting 78+ weeks			0	70	92	149	291	542	726	979	1,176	1,268	1,180	1,318	1,635	1,740	1,416	1,329	952			
	No. patients waiting 104+ weeks			0	0	0	0	0	0	0	0	9	24	66	101	133	178	247	248	273			
	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	20.1	20.1	20.1	17.8	17.8	19.5			
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%	73%	74%	75%	72%	73%	74%	75%	72%	70%			
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%	59%	60%	61%	60%	64%	58%	65%	63%	61%			
	NOFs (Within 36hrs of admission - NHFD)		85%	40%	10%	26%	29%	25%	42%	67%	63%	20%	29%	23%	30%	30%	39%	20%	42%	4%			
Outpatients	**Referral Rates**																						
	GP Referral Rate	*(20/21 baseline)*	-0.5%										200.1%	127.3%	86.0%	66.7%	50.5%	42.0%	38.3%	34.3%			
	year on year +/-	*(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%	-10.8%	-10.8%	-10.9%	-11.3%	-10.7%	-10.2%			
	Total Referrals Rate	*(20/21 baseline)*	-0.5%										169.1%	120.5%	87.2%	70.3%	53.5%	42.6%	37.1%	31.2%			
	year on year +/-	*(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%	-6.2%	-6.0%	-5.6%	-5.8%	-5.0%	-4.6%			
	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	15,389	16,272	16,487	16,174	15,846	16,393			
	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	1.40	1.47	1.48	1.43	1.44	1.49			
	% 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%	6.6%	6.7%	6.9%	6.9%	6.8%	7.1%			
	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%	12.2%	11.7%	13.0%	12.4%	11.8%	14.0%			
	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%	28.7%	28.5%	26.1%	26.6%	26.7%	27.8%			
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%	3.3%	6.1%	5.5%	5.5%	7.8%	14.3%			
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%	79.8%	78.8%	77.3%	74.6%	71.3%	71.4%	66.8%	*(December 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%	75.3%	78.2%	75.2%	72.8%	68.0%	66.4%	62.9%	*(December 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	14.0	10.0	7.0	5.0	4.0	4.0			
	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%	16.1%	17.1%	19.8%	21.4%	24.5%	30.6%			
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205	217	229	239	250	274	266	280	277	298			
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206	223	228	250	280	297	278	294	297	304			
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0	0	0	0	0	0	5	16	21	34			
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072	1674	2110	2735	3656	4349	3679	4258	3980	4071			
	ED attendance Growth (YTD)	*vs 20/21*										94.3%	17.0%	56.1%	45.8%	37.4%	33.2%	31.5%	31.5%	31.5%			
		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%	0.9%	1.7%	2.3%	2.8%	2.5%	2.8%			
SWAST SCAST	Ambulance handover growth (YTD)	*vs 20/21*										43.0%	35.7%	22.9%	14.6%	9.8%	6.1%	2.7%	1.0%	2.7%			
		vs 19/20				-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%	7.8%	8.8%	8.9%	7.3%	1.7%	2.4%	-0.4%	-2.6%	-0.4%			
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190	227	264	341	411	330	290	213	262	281			
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20	42	67	117	168	238	203	127	175	164			
Patient Flow	Emergency admissions growth (YTD)	*vs 20/21*										33.2%	17.0%	2.2%	26.7%	21.1%	17.0%	14.4%	13.1%	14.4%			
		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%	-1.4%	-2.2%	-2.9%	-4.1%	-5.5%	-4.1%			
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%	85.1%	90.5%	90.3%	89.7%	92.5%	90.3%	92.4%	92.4%	91.3%			
	Stranded patients:																						
	Length of stay 7 days				380	394	385	311	443	311	347	338	374	390	407	483	467	475	514	500			
	Length of stay 14 days				197	214	219	155	242	155	184	178	195	216	233	296	294	295	328	318			
	Length of stay 21 days		108		108	126	132	86	144	86	105	103	115	132	148	198	198	202	224	224			
	Non-elective admissions				6089	6279	5673	6034	5231	6034	6130	6355	6463	6366	6486	6119	5972	6291	5852	5621			
	> 1 day non-elective admissions				3796	3932	3554	3686	3521	3686	3737	3873	4025	3885	4108	3950	3756	4009	3727	3575			
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344	1710	2344	2387	2481	2437	2478	2374	2166	2211	2275	2123	2044			
	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%	29.90%	29.00%	28.30%	30.10%	29.90%	32.70%			

Quality - SAFE

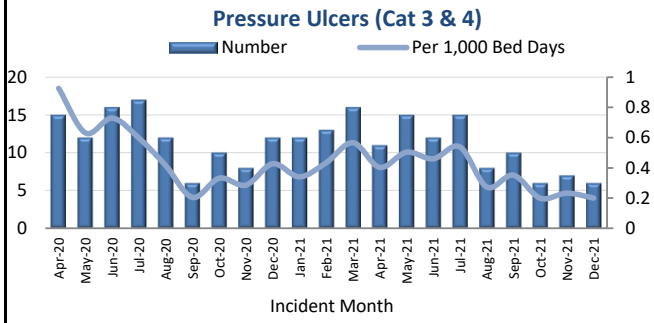
Commentary on high level board position

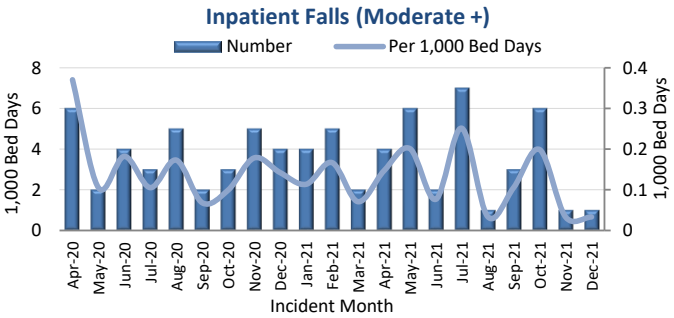
- Six cat 3's reported this month. Two incidents are mixed aetiology, moisture & pressure. Three incidents relate to pre-exisitng damage deteriorating during admission and one category 3 developed during admission.
- One fall moderate harm event this month, patient suffered a # neck of femur following an unwitnessed fall.
- Three (3) new Serious Incidents reported in month (December 21). Full report on learning from completed scoping meeting and investigations included in CMO report to Quality Committee and Board.
- One (1) new Never events reported in month. YTD figure still remains below 20/21 figure.
- Number of patient safety incidents reported to NRLS appears to remain below 20/21. The Risk team are currently reviewing NRLS coding and upload records for 19/20 and 20/21 in order to validate.

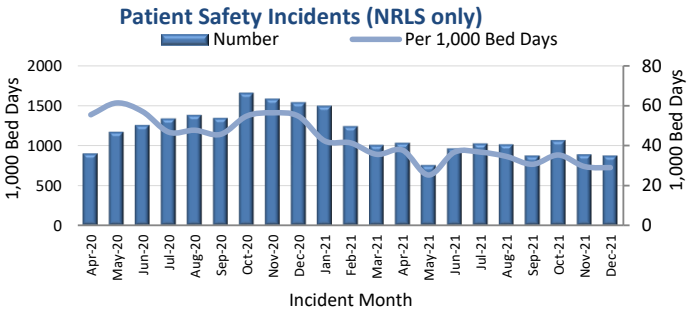
High level Board Performance Indicators

		21/22 YTD	20/21 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	90	108	-18
	Per 1,000 Bed Days	0.35	0.47	-0.12
Inpatient Falls (Moderate +)	Number	31	34	-3
	Per 1,000 Bed Days	0.12	0.15	-0.03
Medication Incidents (Moderate +)	Number	22	24	-2
	Per 1,000 Bed Days	0.08	0.10	-0.02
Patient Safety Incidents (NRLS only)	Number	8,468	12,140	-3672
	Per 1,000 Bed Days	32.68	52.74	-20.06
Hospital Associated Infections	MRSA	1	0	1
These are difficult to compare to 20/21	MSSA	33	37	-4
in terms of pure numbers.	C Diff	57	39	18
See Cover Sheet for more info.	E. coli	66	48	18

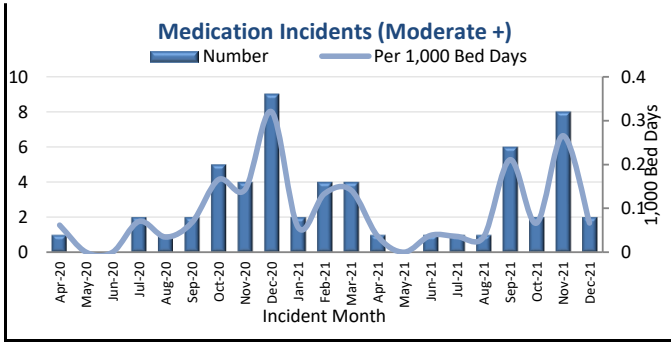
High Level Trust Performance

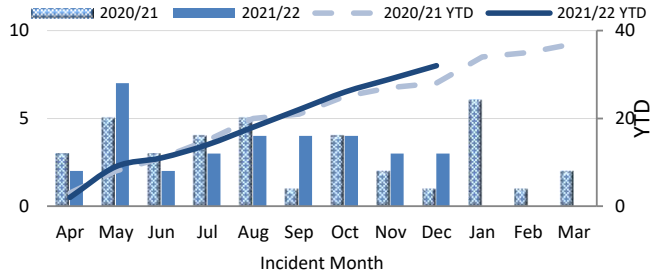


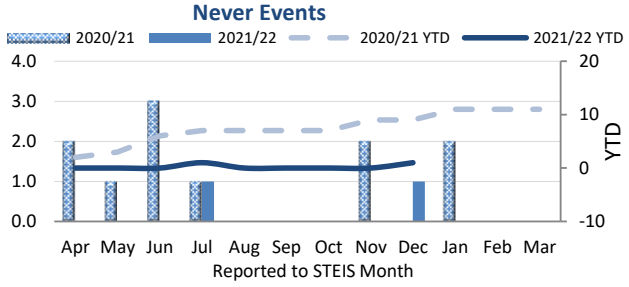




0 (Nov 21) | MRSA | 0 (Dec 21) | 4 (Nov 21) | MSSA | 4 (Dec 21) | 6 (Nov 21) | C Diff | 4 (Dec 21) | 7 (Nov 21) | E. coli | 9 (Dec 21)







Quality - RESPONSIVE

Commentary on high level board position

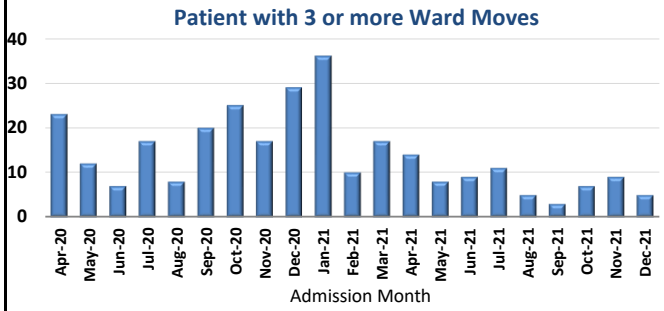
- eNA compliance of the initial assessment completion within 6hrs of admission remains a challenge for admitting areas with complaince remaining static. Membership has been decided for an eNA task & finsh group, with the aim of reviewing the risk assessments and compliance requirements.

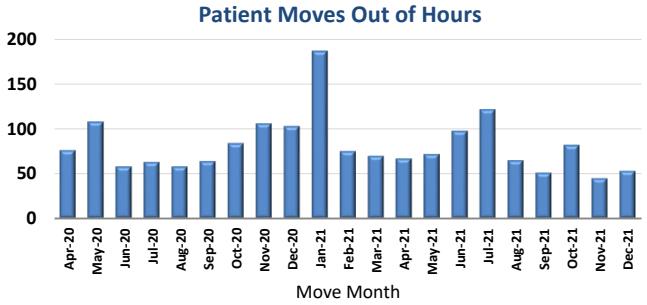
- The trust continues to strive to keep out-of-hours patient moves to a minimum. With Covid-19 cases rising there has been a need to move patients more than we would like in order to maintain good infection prevention and control practice.

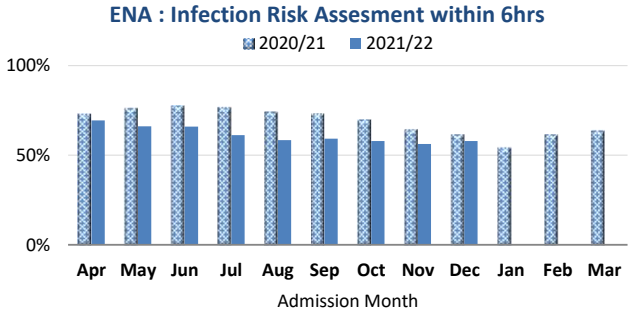
High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)	71	158	-87
Patient Moves Out of Hours (Non-Clinically Justified Only)	655	720	-65
Mixed Sex Acc. Breaches Suspended Apr20 - Sep21	8	N/A	N/A
ENA Risk Assessment			
Falls	57.4%	60.5%	-3.1%
Infection	61.5%	73.4%	-11.9%
MUST	61.7%	63.8%	-2.1%
Waterlow	57.8%	60.2%	-2.4%

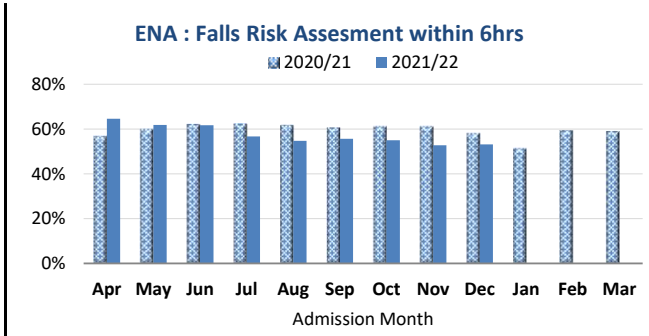
High Level Trust Performance

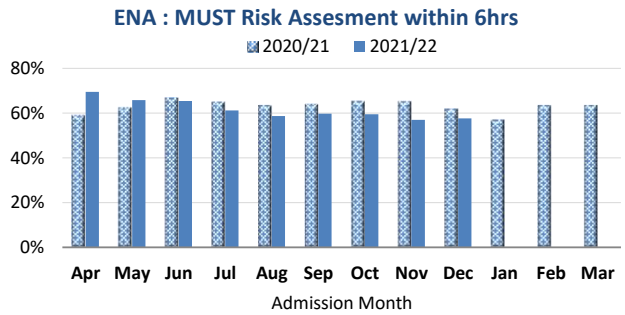


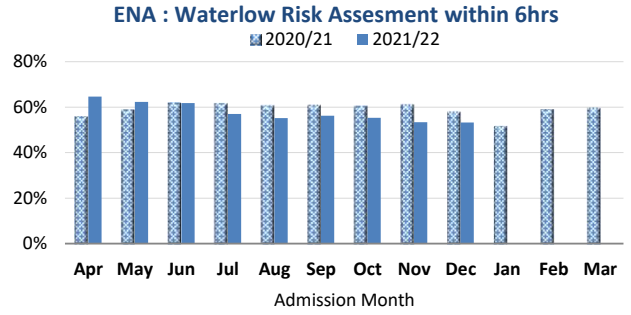




52.8% (Nov 21) Falls 53.2% (Dec 21) | 56.2% (Nov 21) Infection 58.0% (Dec 21) | 56.9% (Nov 21) MUST 57.6% (Dec 21) | 53.3% (Nov 21) Waterlow 53.2% (Dec 21)







Quality - EFFECTIVE AND MORTALITY

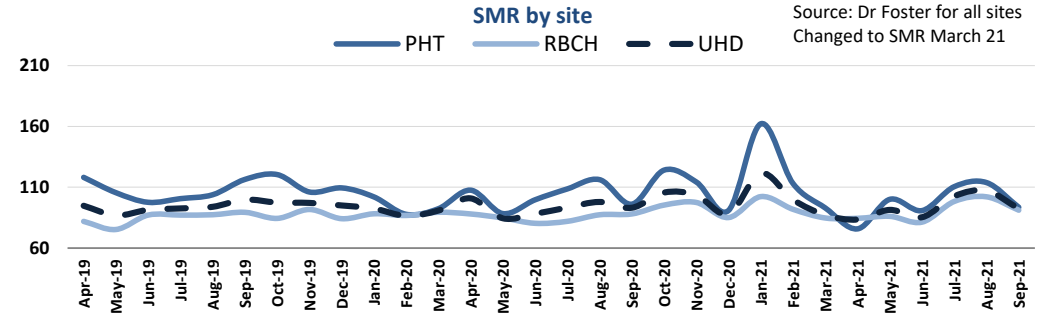
Commentary on high level board position

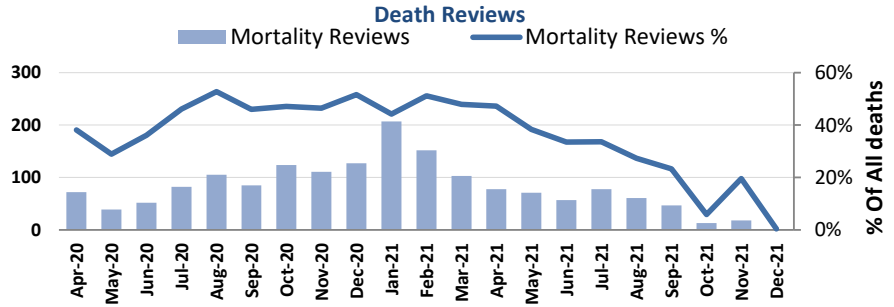
- Please see separate CMO paper regarding Mortality
- An audit of Mortality governance processes started in November 21. The audit will focus on the effective implementation of M&M meetings across the Care groups and the dissemination of learning from completed mortality reviews.
- A project to roll out a new learning from deaths process across UHD has restarted in November. The aim of the project is to implement a single IT system across UHD for the verification of death, mortuary admisssion process, Medical examiner scrutiny and completion of consultant led mortality case note reviews for all inpatient deaths.

High level Board Performance Indicators

		21/22	20/21	Variance
SMR (Source: Dr Foster for all sites)	Latest (Sep-21 - UHD)	92.4	93.2	
Patient Deaths	YTD	1637	1629	8
Death Reviews	Number	423	670	N/A
Note: 3 month review turnaround target	Percentage	28%	44%	
Deaths within 36hrs of Admission		274	277	-3
Deaths within readmission spell		126	120	6
Patient readmitted within 5 days				

High Level Trust Performance

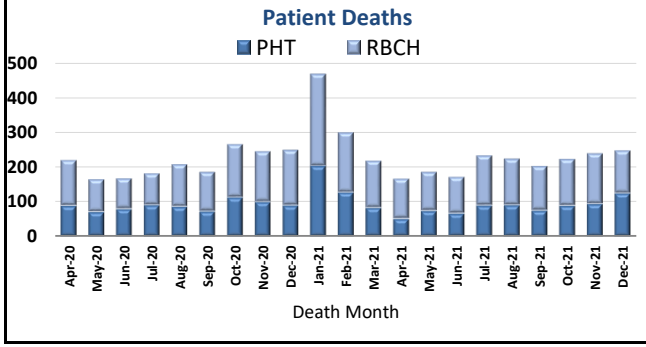


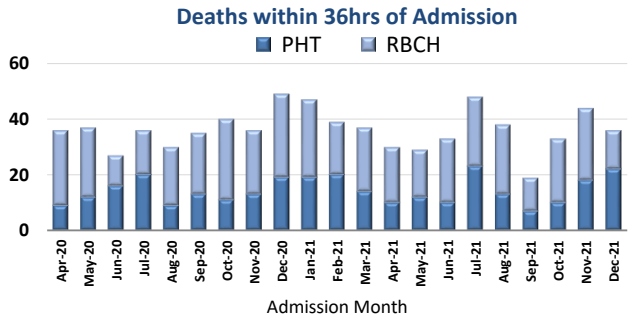


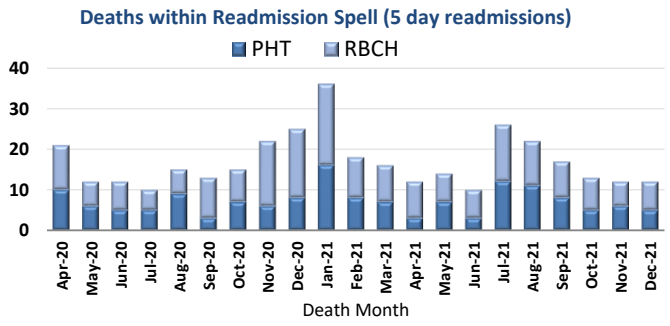
107.1 (Aug 21) | SMR | 92.4 (Sept 21)

238 (Nov 21) | Patient Deaths | 248 (Dec 21)

27.4% (Aug 21) | Deaths Reviewed | 23.3% (Sep 21)







Quality - CARING

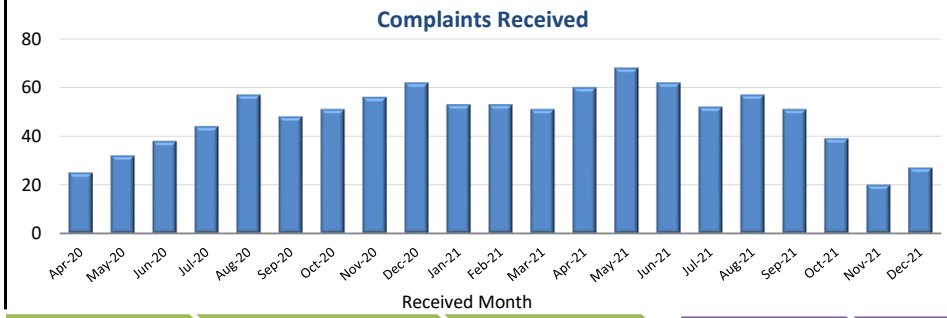
Commentary on high level board position

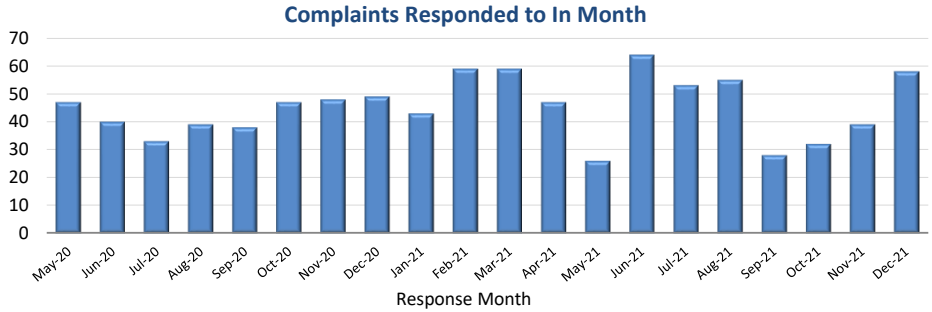
- The Trust continues to achieve good response rates for FFT and the % of patients who report that care is good/very good has increased for the third consecutive month.
- Trust records show that 27 complaints were received during December. However, this is only part of the picture. During the last two months, the patient experience team have focused on promoting early resolution of complaints as an integral part of the new UHD complaints model. However, due to gaps in the workforce, some of this data has not been accurately recorded and this may account for the lower numbers. This data will be corrected for next month.
- The number of complaints responded to in month has significantly improved over the last four months and the backlog of open complaints has reduced. Work will continue to drive the backlog down to more reasonable levels.
- **Key themes from PALS & complaints:** long waits in ED; inability to get through to departments/wards and poor communicationl;staff attitude.

High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Complaints Received	436	413	23
Complaint Response Compliance	TBC		
Complaint Response in month	402	388	14
Section 42's	25	26	-1
Reported quarterly			
Friends & Family Test	88%	91%	-3%
New guidelines from June 2020			

High Level Trust Performance

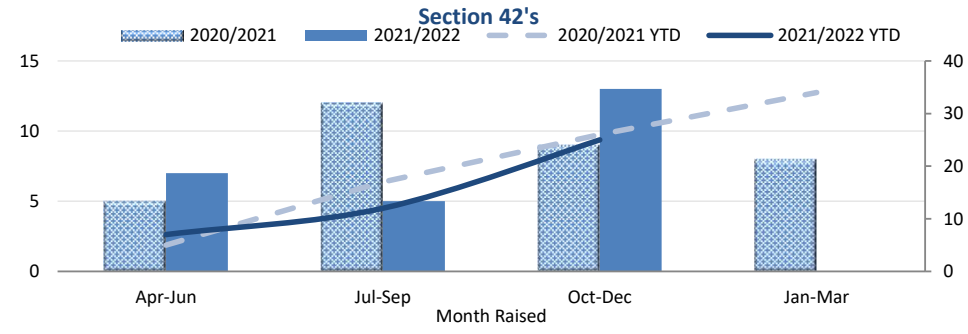


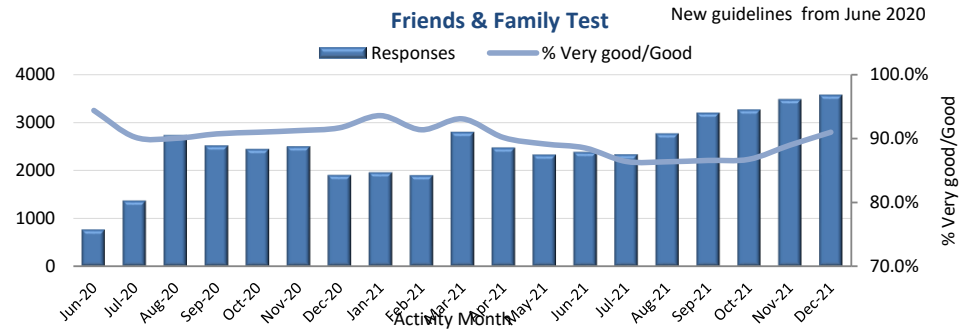


20 (Nov 21) | Complaints Received | 27 (Dec 21)

39 (Nov 21) | Complaint Responses | 58 (Dec 21)

89.0% (Nov 21) | FFT % V.Good/Good | 91.0% (Dec 21)





Quality - WELL LED

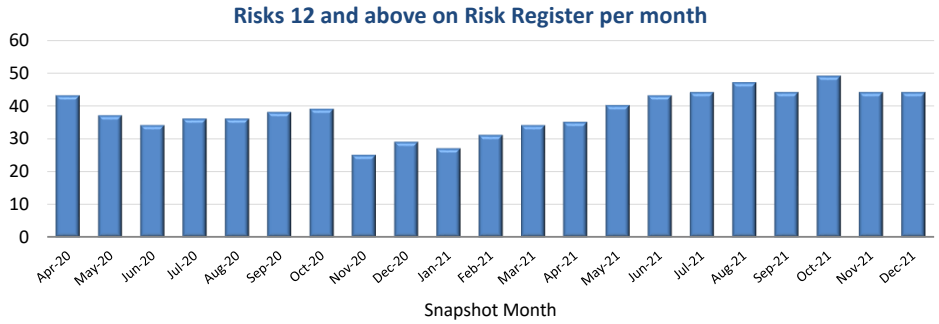
Commentary on high level board position

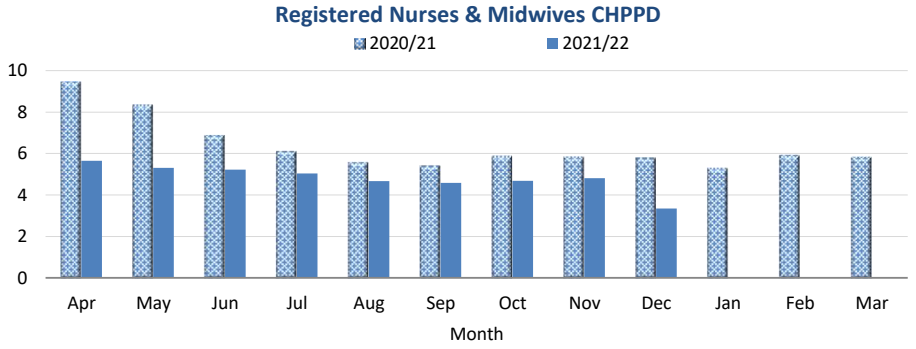
- Risk register update (as at 10/1/2022) provided in TMB, Audit Committee and Board report
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- Specific Heat map risk reports provided to Health and Safety Group and Infection Prevention and Finance and Performance Committee,
- In the context of Covid-19 and the national nurse vacancy picture, safe staffing continues to be a challenge for the Trust. Robust process's for monitoring staffing with senior oversight are in place with the majority of red flags mitigated. CHPPD has dropped in 21/22 due to the national challenges. The national median for Registered nurses and Midwives is 4.7 which placing the Trust on par with peer organisations. It is important to note the significant difference between 2020 and 2021 is linked to historical pre merger data process'.

High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Risks 12 and above on Register	44	29	15
Red Flags Raised* *criteria now aligned across UHD	1009	298	711
Registered Nurses & Midwives CHPPD	4.8	6.4	-1.6
Patient Safety Alerts Outstanding	0	0	0

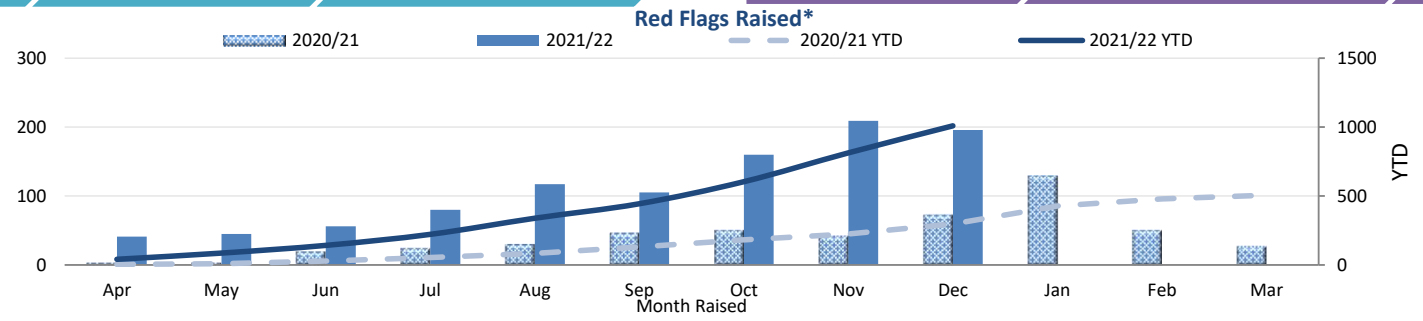
- **High Level Trust Performance**





44 (Nov 21) > Risks 12+ > 44 (Dec 21)

4.81 (Nov 21) > RN & RM CHPPD > 3.34 (Dec 21)



Workforce

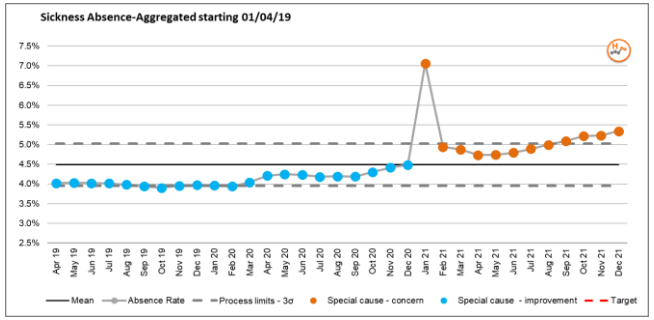
Commentary on high level board position

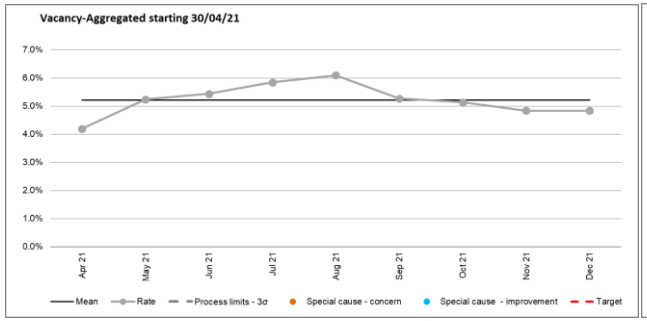
UHD turnover has risen slightly to 12.8% actual this month and is tracking at 12.0% year to date.
Vacancy Rate is showing at 5.2%, an increase of 0.4% on last month. This reflects the increase we have seen in the number of staff leaving the trust. Work continues to refine our data analysis and establishment processing.
Overall Sickness Overall Sickness levels have again increased this month noting added pressure felt on the operations across the site and the impact felt from the Omicron variant. Sickness aligned to Covid has seen a rise from 0.20% to 0.29%.
Medical & Dental appraisal levels have fallen by 9% this month, but overall are tracking higher than last year by 2.7%.
Value based appraisal levels are up slightly again this month by 0.2%. but are still tracking low year to date.
Statutory and Mandatory training compliance continues strong despite continuing disruption to training due to operational pressures.
Temporary Staffing: Volume of requests for temporary staffing is high across all staff groups and specialties; fill rates are lower than previous months for Clinical and Health Care support staff

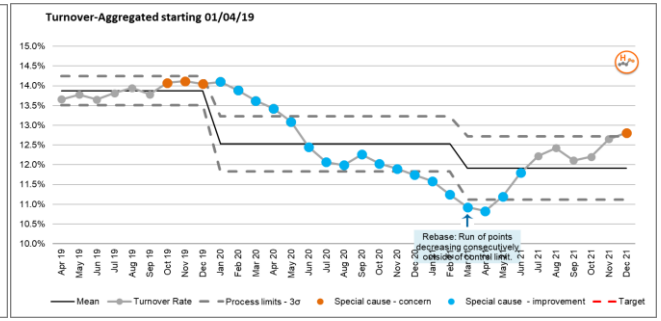
High level Board Performance Indicators

		21/22 YTD	20/21 YTD	Variance
Turnover		12.0%	12.3%	-0.3%
Vacancy		5.2%		N/A
Sickness Rate		5.0%	4.5%	0.5%
Appraisals	Values Based	34.5%	42.1%	-7.6%
	Medical & Dental	57.3%	54.6%	2.7%
Statutory and Mandatory Training		87.3%	86.7%	0.6%

High Level Trust Performance





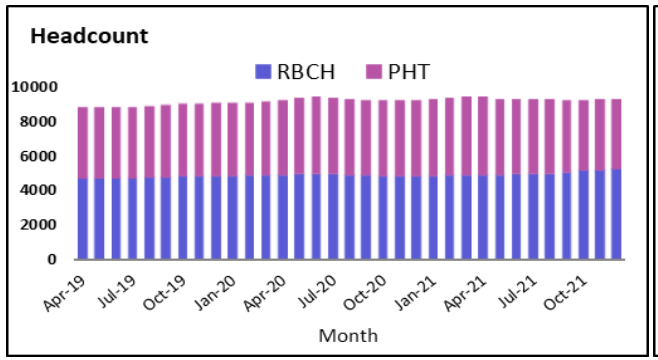


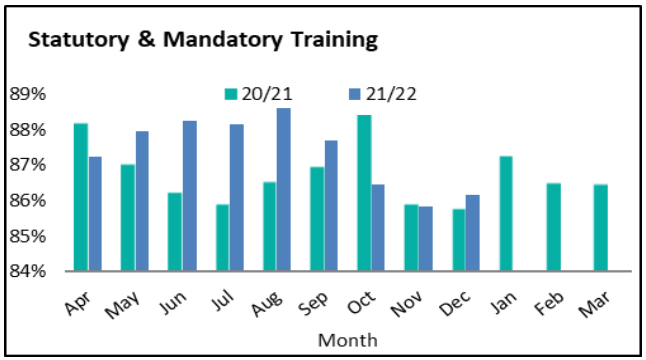
63.1% (Nov21) | Appraisals (Medical) | 54.1% (Dec21)

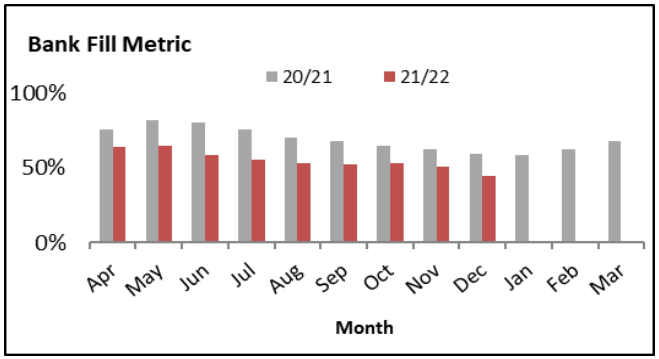
58.2% (Nov21) | Appraisals (Values) | 58.4% (Dec21)

12.6 (Nov21) | Turnover | 12.8% (Dec21)

5.2% (Nov21) | Sickness | 5.3% (Dec21)







Emergency

Commentary on high level board position

UHD continues to experience challenges in our Emergency Departments. Attendance numbers continue to reduce with an average of 37 less per day compared to December 2019, and 30 less per day than in November. There was improved performance of achieving initial assessment within the standard, and an increase in the ratio of patients seen by a clinician within 60 mins of arrival. Mean time slightly deteriorated on the RBH site, with patients wafting in the department more than 12 hours also worsening.

Daily Ambulance activity is similar to November but significantly lower than the same period in 2019 (c30 per day as an average). Ambulance delays were consistent with November with 164 waiting over 60 minutes (175 November). The Trust have been advised by SWAST that in in with national guidance Ambulance crews will no longer support 'cohorting' patients in corridors from January 11th, and the implications of this are being worked through.

Overall admissions are slightly lower than November, with an average of 95 at RBH and 88 at Poole. Patients with no criteria to reside in hospital beds remains high impacting the efficiency of flow on both sites, manifesting itself as increased escalation and crowding in both Emergency Departments.

In January the ECIST review and support plan will be shared with the ED teams and with the Trust Management Group to develop the programme of work required to support improvement.

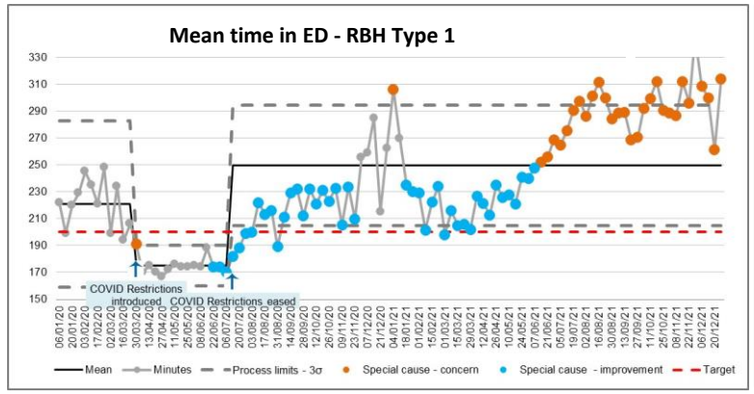
High level Board Performance Indicators

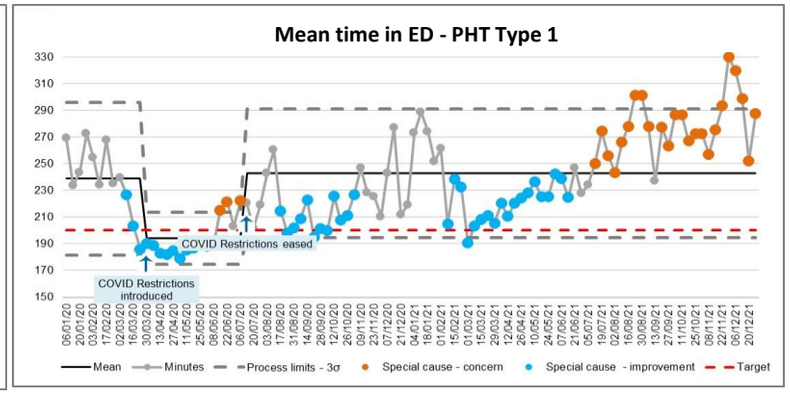
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	4
Clinician seen <60 mins		30.6%
PHT Mean time in ED	200	298
RBCH Mean Time in ED	200	304
Patients >12hrs from DTA to admission	0	34
Patients > 12hrs in dept		418
YTD ED attendance Growth vs 20/21 (vs 19/20)		31.5% (2.8%)
Ambulance Handover		
YTD Ambulance handover Growth vs 20/21 (vs 19/20)		2.7% (-0.4%)
Ambulance handover 30-60mins breaches		281
Ambulance handover >60mins breaches		164
Emergency Admissions		
YTD Emergency admissions growth vs 20/21 (vs 19/20)		14.4% (-4.1%)

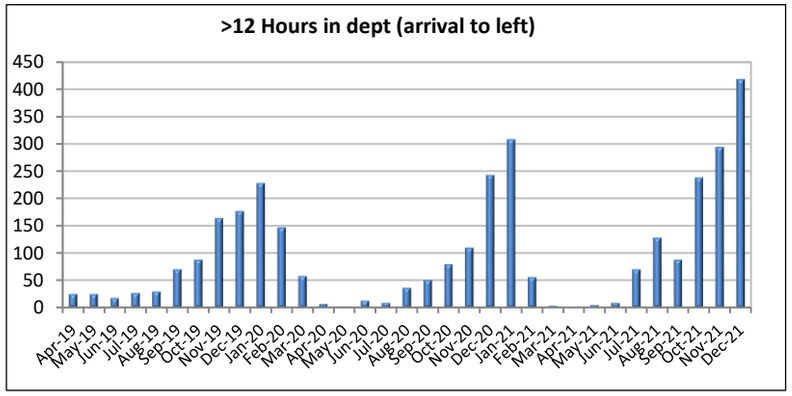
4 mins Nov-21 → Mean time to initial assessment → 4 mins Dec-21

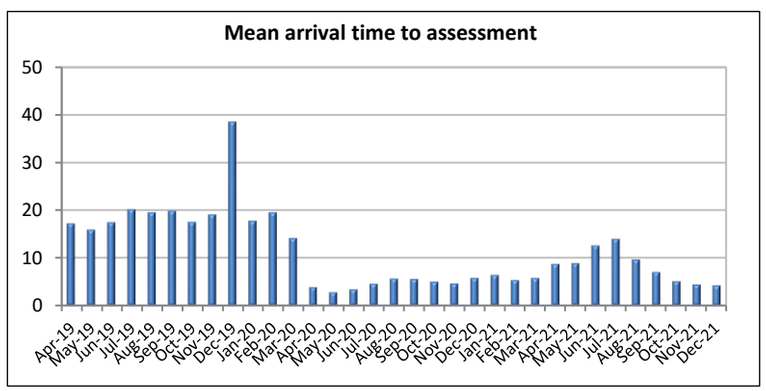
288 mins Nov-21 → Mean time in Dept. RBH & PHT → 301 mins Dec-21

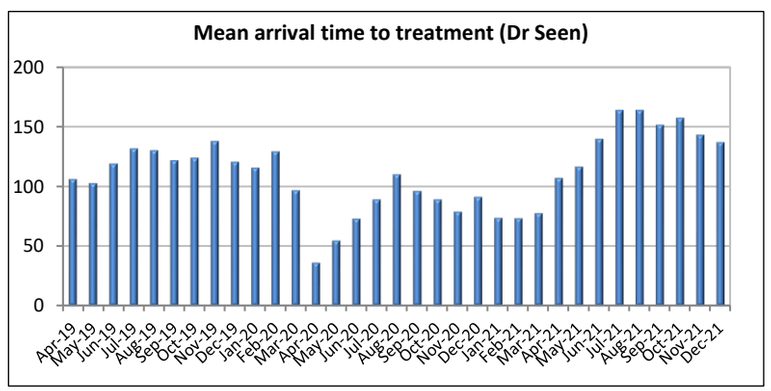
High Level Trust Performance

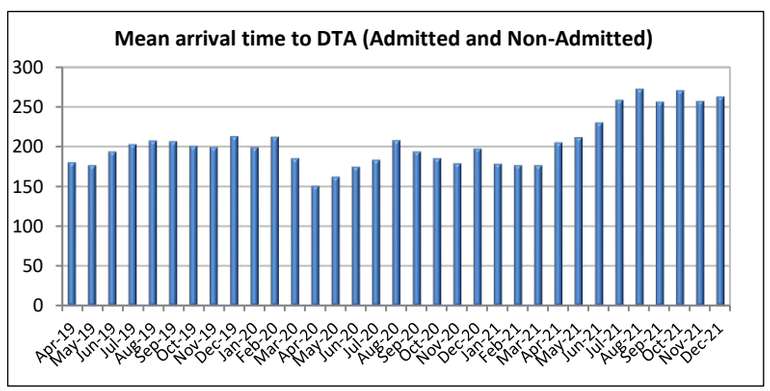












Patient Flow

Commentary on high level board position

Patient Flow

Bed occupancy has reduced in December compared to previous month, 91.3% against 92.4% in November. The improvement can be attributed to a high discharge rate during the Christmas period. However, it is still remains above the 85% Standard. The figure also includes escalation capacity and the Trust was fully escalated during this period. Escalation beds were required due to infection control outbreaks and an increase in covid admissions which impacted on available green capacity.

The ED conversion rate increased in month by 2.8% to 32.7% which is also above the specified standard.

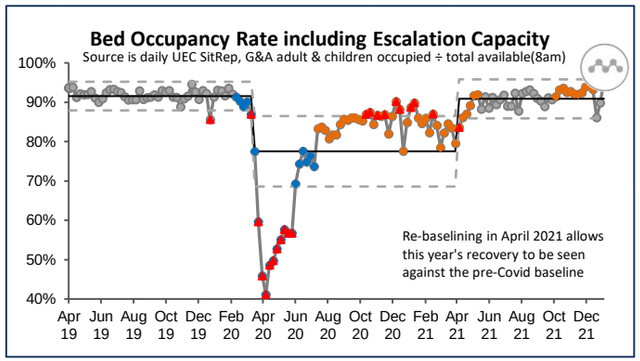
Adult occupied bed days reduced in month by 280 days with a minor reduction in net admissions against discharges (37 less admissions).

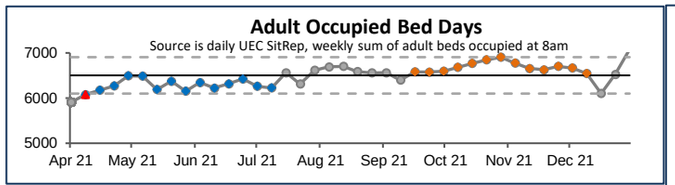
The mean bed wait for patients reduced significantly in December to 169 mins compared to 219 mins the previous month.

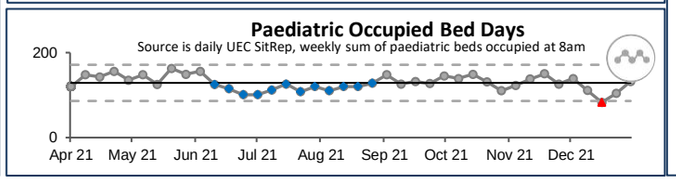
High level Board Performance Indicators & Benchmarking

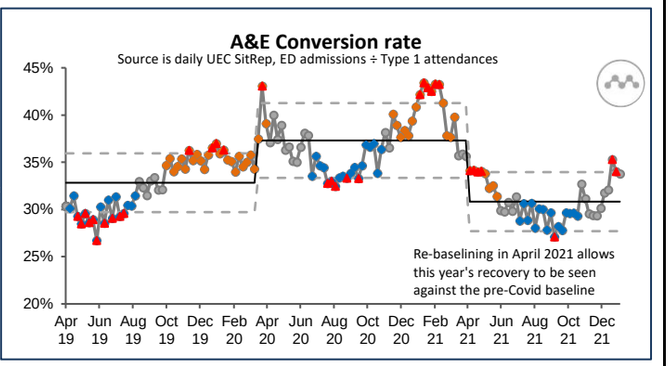
December 2021	Standard	Merged Trust
Patient Flow		
Bed Occupancy		
(incl. escalation in capacity)	85%	91.3%
(excl. escalation in capacity)		92.9%
Occupied Bed Days		29,182
Admissions v Discharges		6,317 v 6,354
Net admissions	<= 0	-37
Non-elective admissions		5,621
> 1 day non-elective admissions		3,575
Same Day Emergency Care (SDEC)		2,044
Conversion rate (admitted from ED)	30%	32.7%
Mean bed wait: minutes *w/c 3 Jan*		169.4

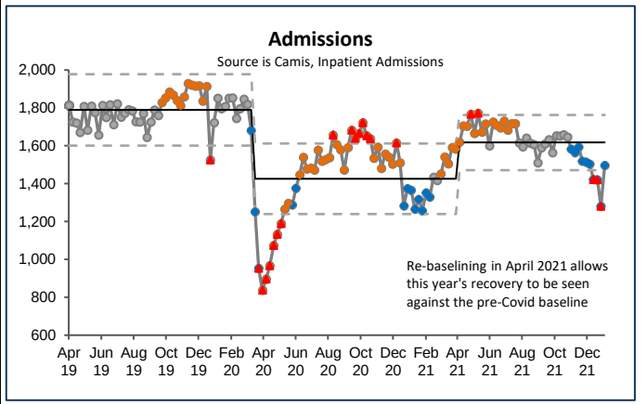
High Level Trust Performance (weekly)

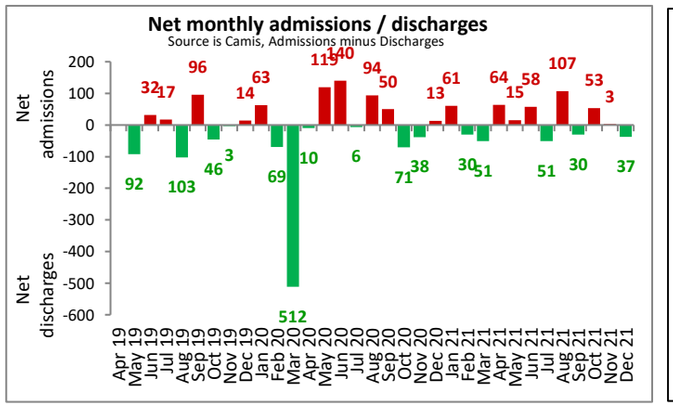


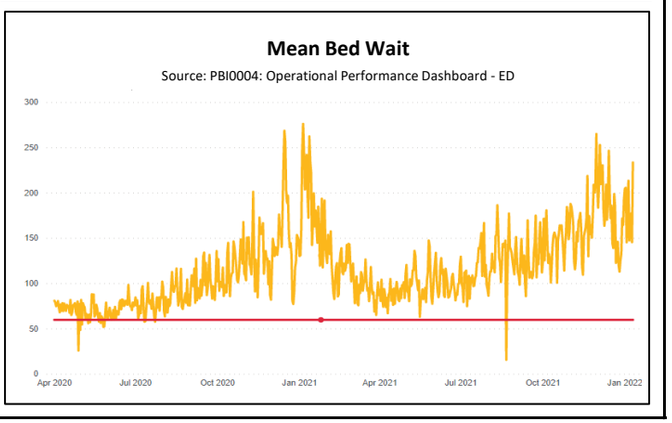












Length of Stay and Discharges

Commentary on high level board position

Patient Flow

The average number of beds per day occupied by patients with a length of stay>7days has slightly reduced in month (-14 patients). The number of patients with a length of stay over 21 days remained at 224 and the proportion of this cohort of patients increased by 1% and remains above pre pandemic levels. The overall increased stay for stranded patients remains above the standard and continues to cause operational challenges to managing flow and has a detrimental impact on the national UEC metrics.

The number of patients who are ready to leave/have no reason to reside (MRTL/NRTL) has decreased with an average of 166 patients waiting in month compared to 174 in November. The position improved with the introduction of block booked beds being provided in the community. The overall proportion of NRTR patients worsened in month to 23% (increase of 1%). Internal processes account for 17% of the patients no longer meeting the criteria to reside (CTR), an improvement of 7% on the previous month. Data completeness in relation to whether a patient has C2R has marginally dropped to the 78% mark. Further work is needed to improve this position.

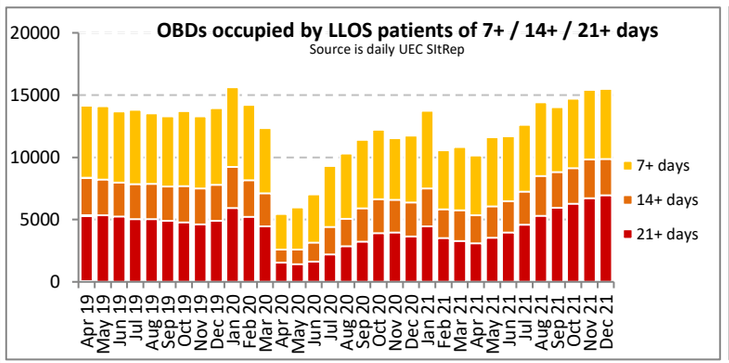
High level Board Performance Indicators & Benchmarking

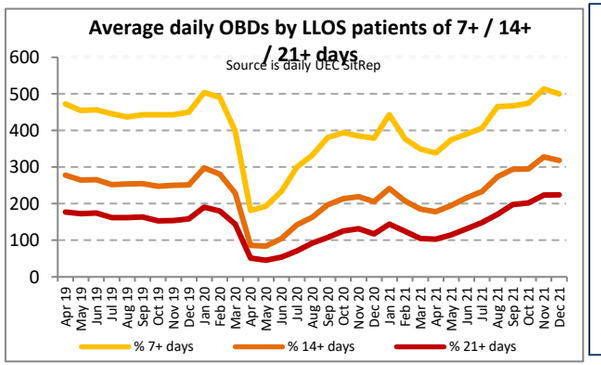
December 2021	Standard		Merged Trust	
Length of Stay and Discharges				
Stranded patients:				
Length of stay 7 days		*42%*	500	*53.1%*
Length of stay 14 days		*21%*	318	*33.8%*
Length of stay 21 days	108	*12%*	224	*23.8%*

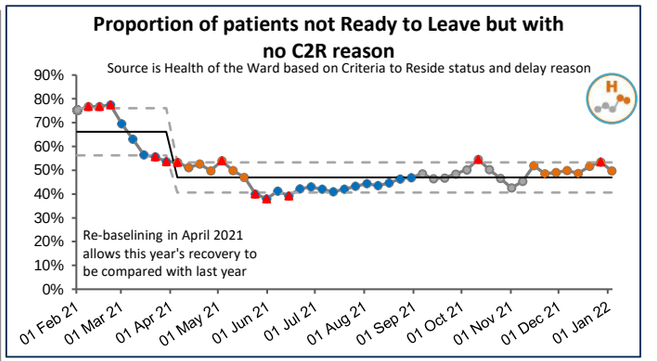
Criteria to Reside (excludes Ready to Leave)	Physiology	5%
	Function	11%
	Treatment	25%
	Recovery	8%
	Not Recorded	**51%**

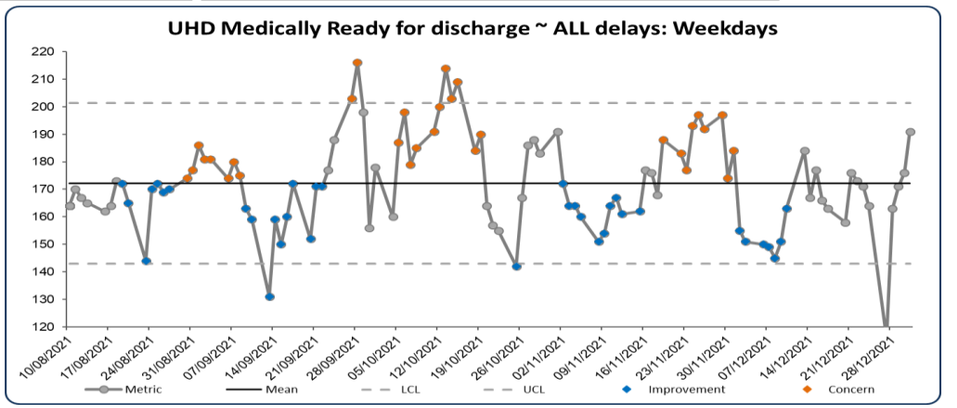
Proportion of patients who are Ready to Leave 23%

High Level Trust Performance (weekly)









Escalation Report

Dec-21

Trauma Orthopaedics : 18% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

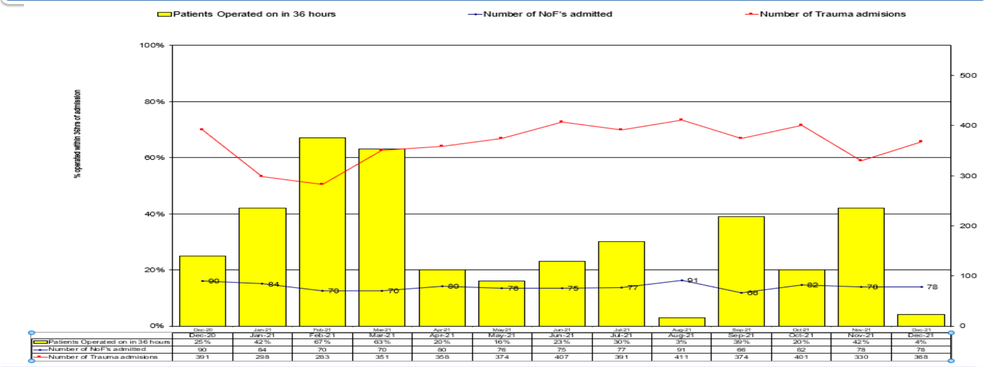
Definition of Trauma Quality Targets & Compliance Achieved

NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission.
Dec 2021 Compliance: 4%
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).
Dec 2021 Compliance: 18%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
Dec 2021 Compliance: 85%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	10
Patients on anti coagulants	1
Other NoF/trauma patients prioritised	53
Loss of weekend capacity due to theatre staffing	0
Awaiting x-ray/scan availability	0
Required medical review pre-op	0
Equipment failure	0
Awaiting specialist surgeon	5
Total breached NoFs	69

Demand on Trauma Directorate during December 2021



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Patients Operated on in 36 hours	25%	42%	67%	63%	20%	16%	23%	30%	9%	39%	20%	42%	4%
Number of NoF's admitted	90	84	70	70	80	76	75	77	91	66	82	78	78
Number of Trauma admisions	391	298	283	351	358	374	407	391	411	374	401	330	368

Escalation Activity in November 2021

December proved to be a challenging month for the trauma service with 368 admissions including 78 patients with a fractured neck of femur (# NOF) and 13 with a femoral shaft #. The performance figures in December deteriorated having started the month in a poor position with 11 patients with a # NoF outstanding, patients admitted at the start of the month with a # NoF did not go to theatre until the 4th December which has a knock on effect on going throughout the month. Multiple days of high admissions of #NOF patients, 11 in one 2 day period and 10 in another 2 days. Achieving the 36 hour target was also impacted with the loss of theatre lists over the Christmas and New Year bank holiday periods.

The service spent the majority of the month in stage 2 of escalation moving into stage 3 for a 5 days and stage 1 for 3 days, though after the Christmas period the service moved to high stage 2 with 44 patients awaiting surgery having admitted 7 NoFs on Christmas day and with urgent trauma cases clinically prioritised throughout the month (loss of theatre lists over the bank holiday period) leading to difficulty in recovering perform recover performance.

Mitigations and Reset

Application of national clinical guidelines: Major trauma, #NOF, Spinal, discharge, flow.
Bi weekly Trauma Steering Board in place to review opportunity and blocks to safety, productivity and efficiency. Remedial action plan created and action log in place.
Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate.
Virtual fracture clinic capacity increased to provide same day access.
Bed base, reduction in core capacity to provide Blue Covid capcity and Critical Care capacity
No change in the average daily NOF admissions leading to backlog of patients awaiting surgery.
Daily trauma operational huddle in place
Availability of timely fracture clinic reviews, both face to face and via telephone. additional sessions planned January
Recruitment under way for consultant posts to support Derwent 3rd theatre.
Trauma Ambulatory Care Unit (TOACU) opened at the end of July 80% admission avoidance rate improving to 90%. service impacted over holiday period as capacity used for inpatient capacity for 3 days.

Complexity of Case Load

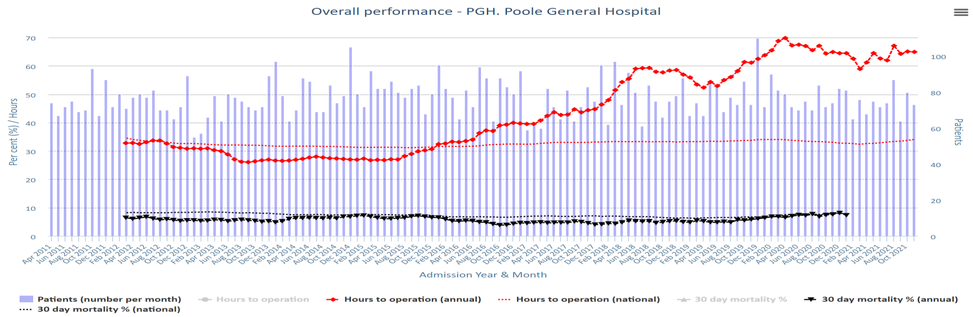
Soft Tissue	No. of pts
Patients requiring returns to theatre	7
Additional theatre slots required	13
Complex Surgery	**No. of pts**
Total Hip Replacements for NoFs	10
Revisions carried out	0

A high number of complex patients in month with 10 # NoF patients had a THR for their fracture, and 8 of 13 patients admitted with a femoral shaft fracture required surgery

The service records on the NHFD all femoral fractures over the age of 60, and the most recent facilities audit for the NHFD focused on femoral shaft fractures.

7 patients required 2 or more trips to theatre this month, equating to an additional 13 theatre visits, which is approximately 4 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

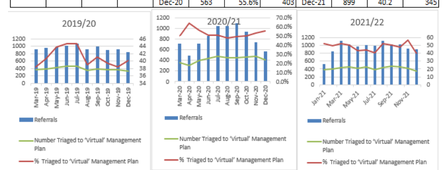
Neck of Femur QSPC Focus



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, Edbaston	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
University Hospital of North Staffordshire	STO	763	65.7	51.1	84.9	27.1	21.8	15.7	85.8	38.2	79.1	92.2

December Update on virtual fracture clinic

2019/20				2020/21				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	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Jan-20	860	40.2	314	Jan-21	518	52.5	383
Apr-19	953	40.6	387	Feb-20	889	39	365	Feb-21	852	50	400
May-19	972	43.7	425	Mar-20	716	50.4%	361	Mar-21	1117	52.1	438
Jun-19	1012	44.6	451	Apr-20	484	63.6%	308	Apr-21	1039	50.6	452
Jul-19	1064	44.6	467	May-20	716	55.9%	400	May-21	972	43.7	425
Aug-19	926	38.9	352	Jun-20	861	50.8%	438	Jun-21	1012	44.6	451
Sep-19	988	41.1	375	Jul-20	1040	51.1%	473	Jul-21	988	41	375
Oct-19	899	39.4	365	Aug-20	1038	47.8%	448	Aug-21	1117	52.1	438
Nov-19	924	38.4	355	Sep-20	1100	49.3%	452	Sep-21	1040	51.1	473
Dec-19	832	40.2	332	Oct-20	934	50.3%	467	Oct-21	1038	47.8	448
				Nov-20	743	53.2%	478	Nov-21	928	56.8	425
				Dec-20	563	55.6%	403	Dec-21	899	40.2	345



In comparison to 2019 activity there has been 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% versus 40% in 2019. This has undoubtably helped to mitigate demands on face to face fracture clinics and remains a huge success.

Author John West

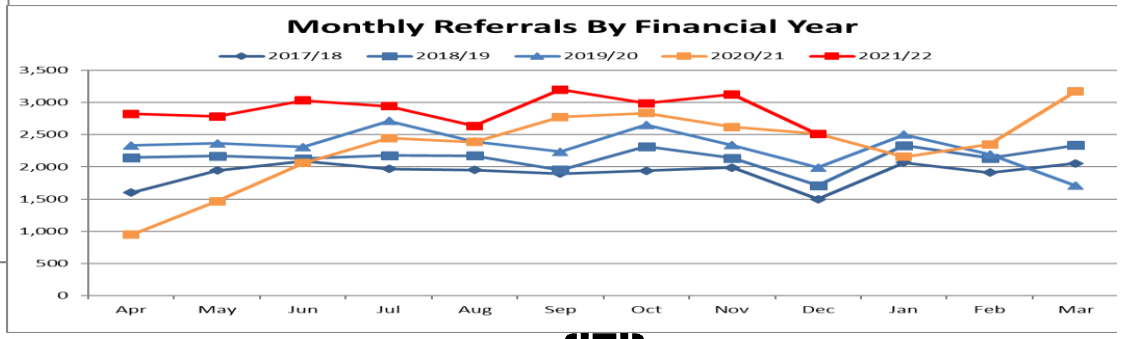
Cancer - Actual November 2021 and Forecast December 2021

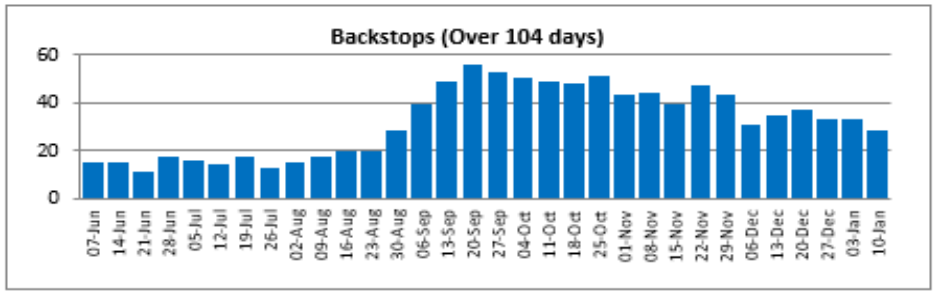
Commentary on high level board position

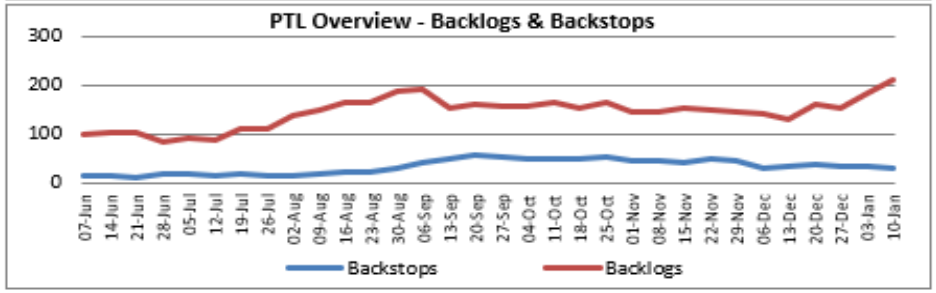
The Trust continued to receive a significant increase in referral numbers in November (16% increase compared to same period last year) and a 14% increase against the planned trajectory. The tumour sites seeing the highest increases were colorectal (30%), lung (24%), skin (27%), and haematology (39%). The total number on the UHD PTL in November remained above 3600 which was considerably larger than previous years with UHD having the 12th highest PTL nationally. The number of patients on a fast track pathway continue to challenge all performance standards. However, of the 30 trusts with the largest PTL's nationally, UHD has the 2nd lowest % of backstop patients (lowest reported position since August 2021), even with the current challenges. 28-day FDS in November dropped to below the 75% threshold, reporting 66.4%. 1st OPA capacity was the main breach reason (56%). Sites that are most challenged are breast, colorectal, gynae and urology. Data completeness in November against this standard was above the target of 95% (95.1%). The Trust has consistently achieved the 31-day standard between April – November 2021 and is also expected to be achieved in December. The Trust also achieved all 3 subsequent treatment KPI's in November with similar performance expected in December. Although the 62-day performance in November was below the 85% threshold (71.%), this is above the current national average of 68.3%. In November, the total number of 1st treatments for patients on a 62-day pathway was 22 above number reported in the same period last year.

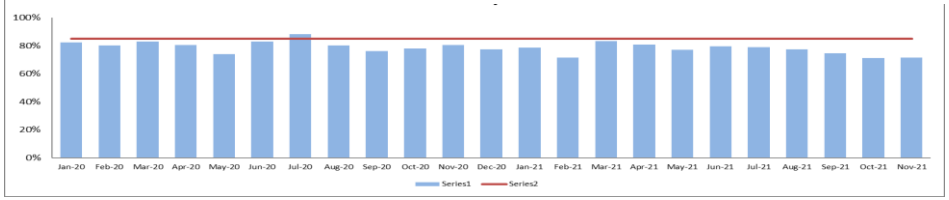
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD Nov-21	Predicted Dec-21
31 day standard	96%	96.8%	96.6%
62 day standard	85%	71.4%	66.8%
28 day faster diagnosis standard	75%	66.4%	62.9%

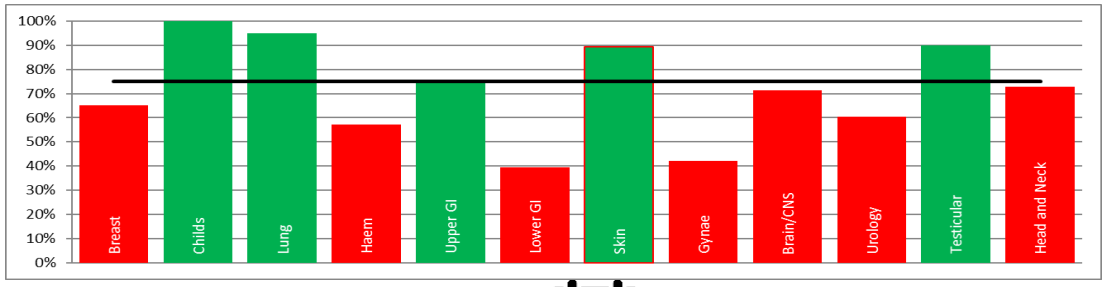




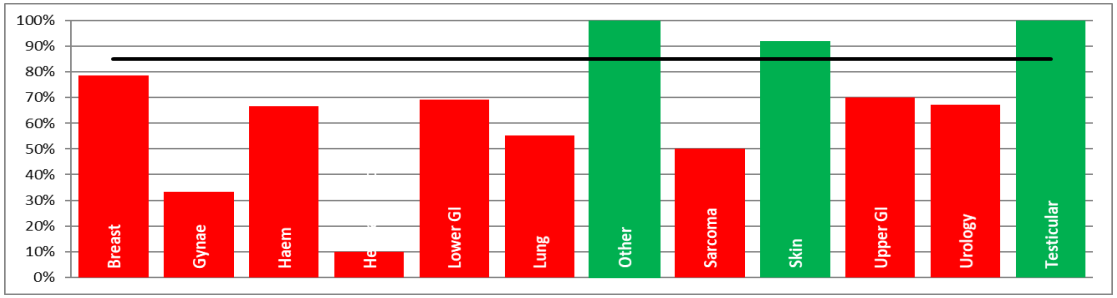




Target 75% | 28 | UHD: November 2021: 66.4%



Target 85% | 62 | UHD: November 2021: 71.4%



Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of December 2021, the Trust's 18 week RTT performance is **61.6%** (92% standard).

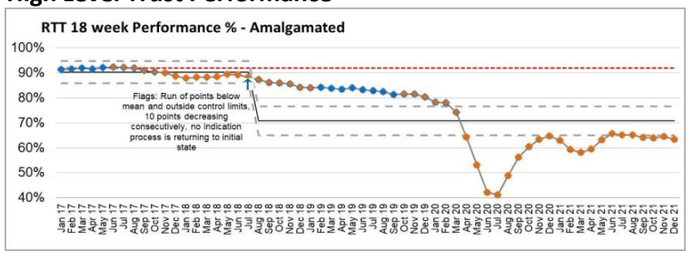
- 2,968 patients were waiting over 52 weeks for treatment, a decrease of 354 compared to November The percentage of the waiting list now over 52 weeks has also reduced to **5.6%** .
- 952 patients are waiting over 78 weeks, a reduction since November whilst 273 patients are waiting over 104 weeks, an increase of 25 since the previous month.
- Specialty level improvement trajectories are in place and governed by the Care Groups with oversight of delivery through the Operational Performance Group
- The overall **waiting list size** has grown in 21/22 for multifactorial reasons, including: reduced capacity during the pandemic; transfer of routine waiting lists/activity from Dorset Healthcare University NHS FT and Dorset County Hospital NHS FT to the Trust as part of the system recovery plan; and the impact of workforce challenges in a number of areas.
- Our waiting list validation programme is continuing across our RTT, follow up and planned waiting lists.
- **99.97%** of patient referrals have been allocated a clinical prioritisation code (P code) with fewer than 5 not yet recorded on the patient administration system (PAS).

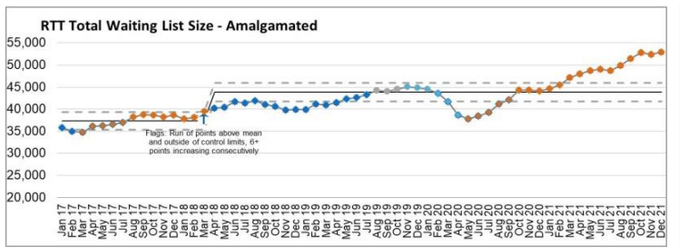
Theatre utilisation The current theatre (main) utilisation rate has **decreased by 1%** since last month.
Trauma The percentage of patients with a fractured neck of femur treated within 36 hours of admission (4%) has deteriorated substantially since last month (42% November 21).

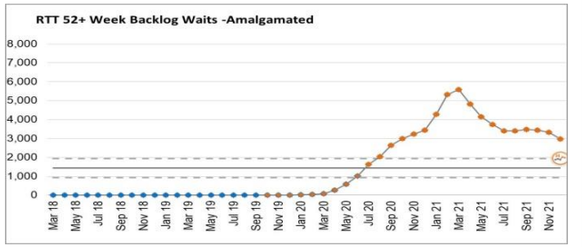
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	61.6%	
Waiting list size	51,491	52,972	23%
Waiting List size variance compared to Sep 2021 %	0%	2.9%	
No. patients waiting 26+ weeks		12,904	38%
No. patients waiting 40+ weeks		5,374	54%
No. patients waiting 52+ weeks (and % of waiting list)	5.6%	2,968	65%
No. patients waiting 78+ weeks		952	74%
No. patients waiting 104+ weeks		273	89%
Average Wait weeks	8.5	19.5	
% of Admitted pathways with a P code		99.97%	
Theatre metrics			
Theatre utilisation - main	80%	70%	
Theatre utilisation - DC	85%	61%	
NOFs (Within 36hrs of admission - NHFD)	85%	4%	

High Level Trust Performance

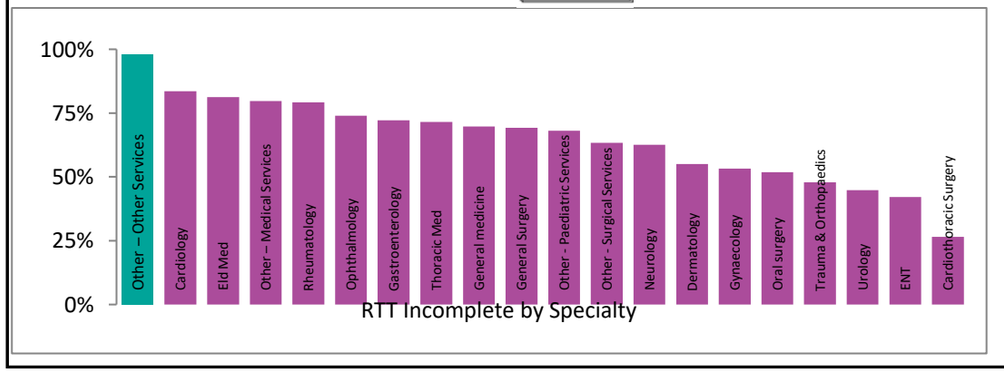


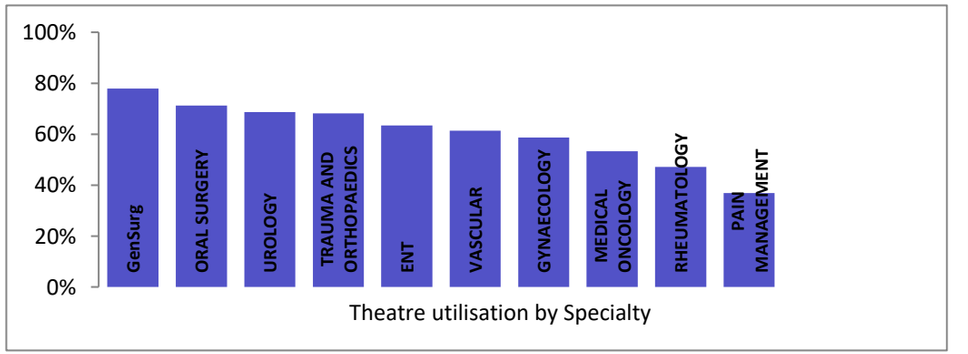




RTT Incomplete 61.6% <18weeks 18 WEEKS (Last month 64.0%) Target 92%

Theatre Utilisation 68% (Last month 69%)





Referral to Treatment (RTT)

What is driving under performance?

92% of all patient should be seen and treated within 18 weeks of referral.
61.6% of all patients were seen and treated within 18 weeks at the close of December 2021.
The overall waiting list (denominator) was **52,984** which is higher than previous months and 2.9% above the September 2021 waiting list of 51,491.

2,968 RTT waits exceeded 52 weeks, which is an improved position and aligned with the Trust's operational plan trajectory for Sept 2021-March 2022.

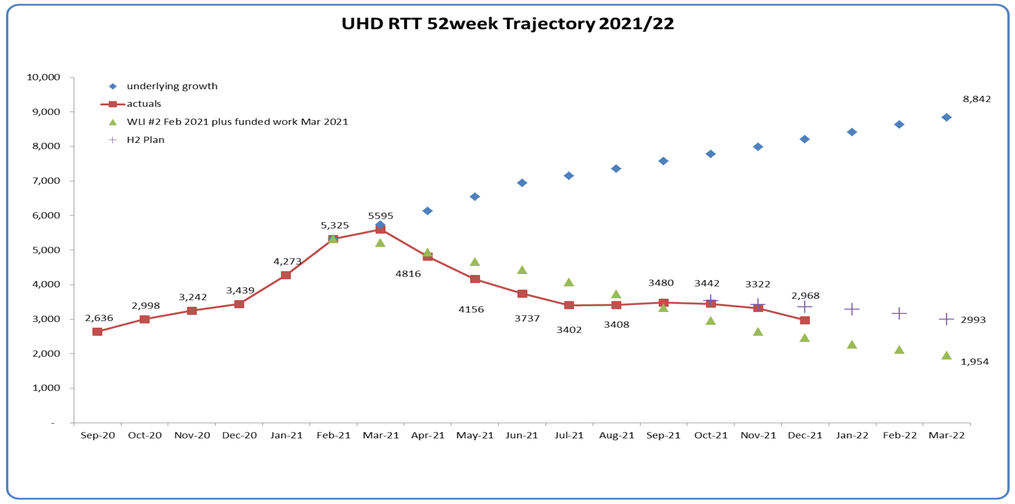
December 2021 (compared with previous month)

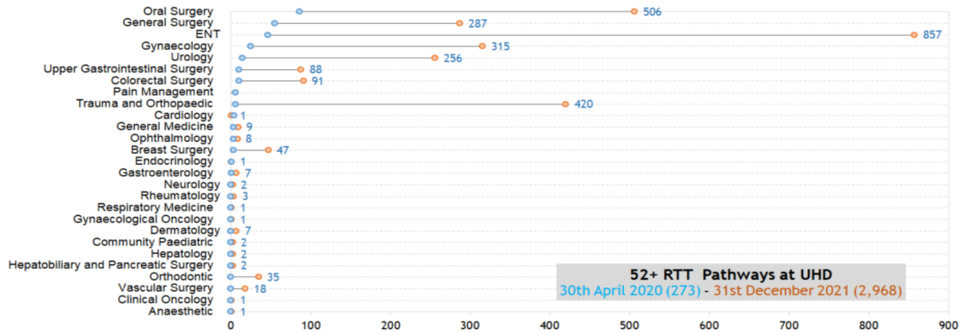
32,657 decrease < 18 weeks
12,904 increase > 26 weeks
5,374 decrease > 40 weeks
2,968 decrease > 52weeks
952 decrease > 78 weeks
273 increase > 104 weeks

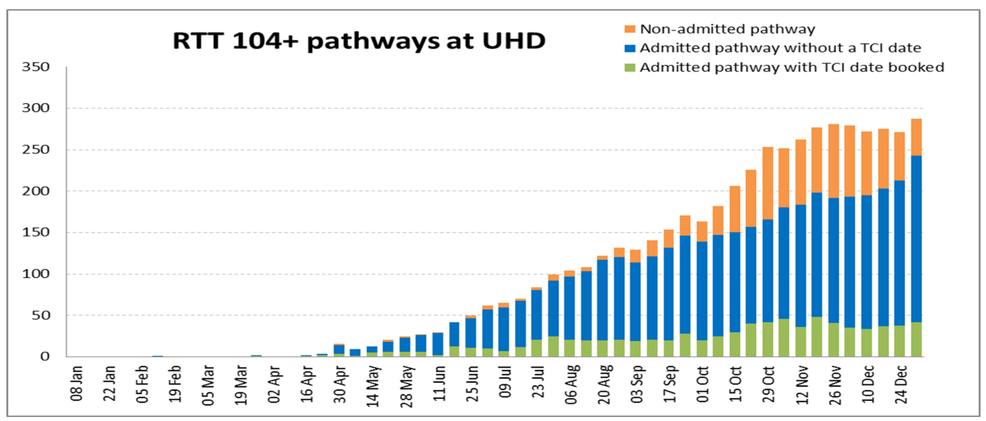
During December maintaining recovery of elective activity has remained a challenge alongside our continued focus on responding to COVID activity, managing an increase in non-elective demand, adhering to national guidelines on social/physical distancing, shielding and self isolation (patients and staff) and management of workforce capacity shortfalls in a number of areas. This has led to a reduction in routine elective activity including outpatient appointments and surgical procedures compared to 2019/20. Independent sector providers continue to provide capacity to support recovery of elective waits.

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, including patients choosing to wait until the pandemic is over or they have been fully vaccinated. Patients' concerns about time away from work or family commitments has also influenced their decisions.
- 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 reducing routine capacity / activity
- Workforce has been redeployed to support the response to managing COVID-19, notably to support critical care
- Surgical/theatre capacity has been diverted to respond to an increase in Trauma activity.







What actions have been taken to improve performance ?

An Elective Operational Performance, Assurance and Delivery (OPAD) programme is in place 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 a number of workstreams to support continuous improvements with the main programmes of work being:

- Validation & clinical prioritisation of all waiting lists commenced in April; Extension of the digital enabled validation programme includes neurology services in December 21.
- Delivery of the Single PAS project to support merged teams to manage single UHD waiting lists.
- Standard operating procedures which support the trust's Access Policy are being developed alongside moving to a single PAS and the merger of teams to increased standardisation and reduce variation.
- Opening of the 'Think Big' Outpatient centre at Beales in Poole to help tackle our waiting lists and bring diagnostic services closer to the community, as part of the Dorset 'Health Village' approach.
- Establishing 52+ week wait improvement trajectories and deploying demand and capacity tools to support management /tracking of improvements
- Continued improvements in business intelligence to support and monitor recovery.
- The operating model for the surgical admissions team is under review to enable best use of this essential resource.
- Mutual aid arrangements across the Dorset ICS are in place to reduce patient waits. Additional capacity using local independent sector providers and/or Insourcing companies has also been optimised.
- Two Trust-wide improvement programmes have also commenced:
  - Theatre improvement programme: value and efficiency
  - Outpatient Enabling Excellence and Transformation programmes

104 week-waiters improvement plan
To support a reduction in the Trust of people waiting over 104 weeks, local recovery plans are in place and additional monitoring and tracking of improvement has been established.

Health Inequalities
The Trust continues to support work to tackle health inequalities through the Dorset ICS Health Inequalities in Elective Care Programme. The programme is in the intervention design stage for two cohorts of patients waiting elective care i) People waiting times > 18 weeks and from deprived communities ii) People on Orthopaedic waiting lists. Currently a process of re-identification of patients to identify named patients in these cohorts is taking place. Patients in these cohorts will then be contacted to support them to access community services that will enable them to wait well. For example, community groups, exercise and weight loss programmes, support with shopping or transport or stop smoking services/advice.

Executive Lead Mark Mould | Trustwide Lead | Author Judith May

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- GP Referrals down 4% on last month
- Patient cancellations are high and have increased to 7.1% an increase of 2.2% on last month.
- Non Face-to-Face attendances - performing above the national standard
- An outpatients improvement programme is focussing on a 'back to basics' review of processes to ensure best practice in Outpatients
- Aligned to this will be delivery of the key requirements identified in the Sept 2021-March 2022 planning guidance (12% advice and guidance, 2% patient initiated follow-up and maintaining at least 25% remote delivery of outpatient attendances)

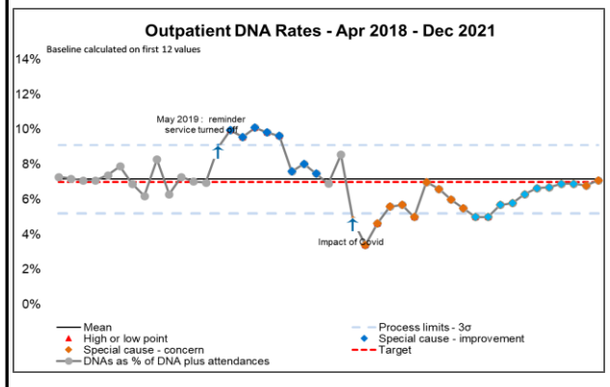
Diagnostics

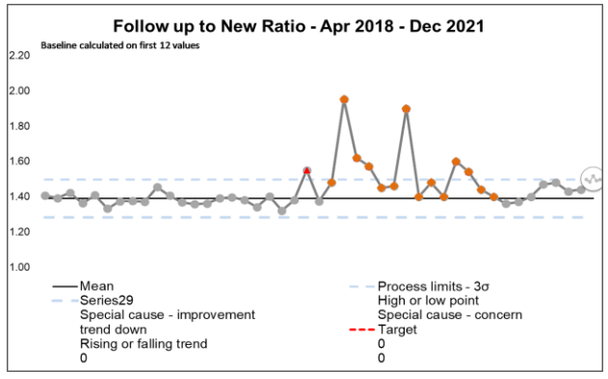
- Decrease against October position from 94.4% to 92.8% of all diagnostics tests required within 6 weeks
- Endoscopy position has slipped from 75.8% in October to 72.7% in November
- Echocardiography has slipped from 86.4% in October to 62.2% in November
- Neurophysiology has improved from 99.7% in October to 100% in November
- Radiology continue meeting the 99% target now at 99.4% for November

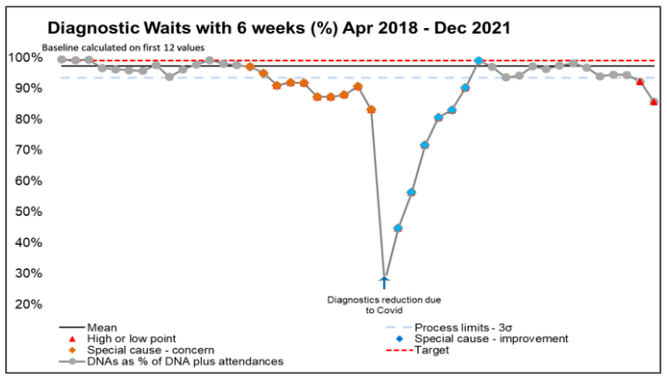
High level Board Performance Indicators & Benchmarking

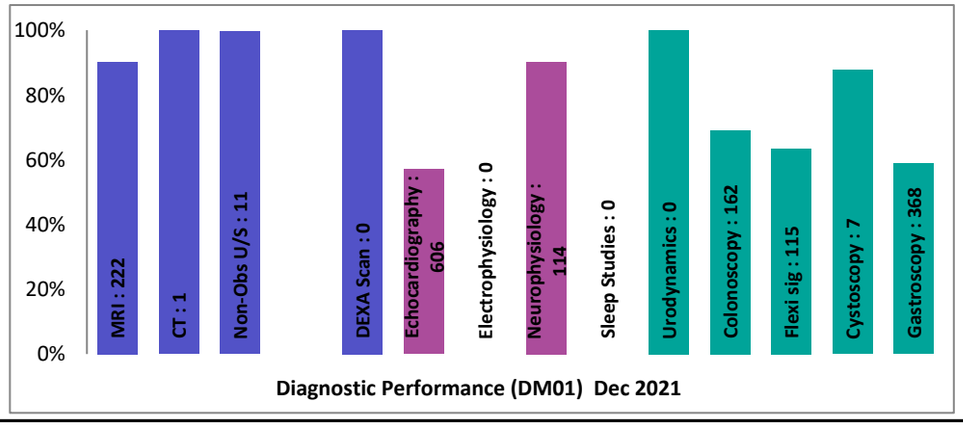
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 20/21 v 21/22)*	-0.5%	71202 / 95614	34.3%
	(values 19/20 v 21/22)		106481 / 95614	-10.2%
Total Referrals Rate year on year	*(values 20/21 v 21/22)*	-0.5%	129310 / 169647	31.2%
	(values 19/20 v 21/22)		177752 / 169647	-4.6%
Outpatient metrics				
Overdue Follow Up Appointments				16,393
Follow-Up Ratio		1.91		1.49
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	30056 / 2282	7.1%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		30056 / 4882	14.0%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*	25%	30056 / 8354	27.8%
Diagnostic Performance (DM01)				
% of >6 week performance	*(Total / 6+ Weeks)*	1%	11220 / 1606	14.3%

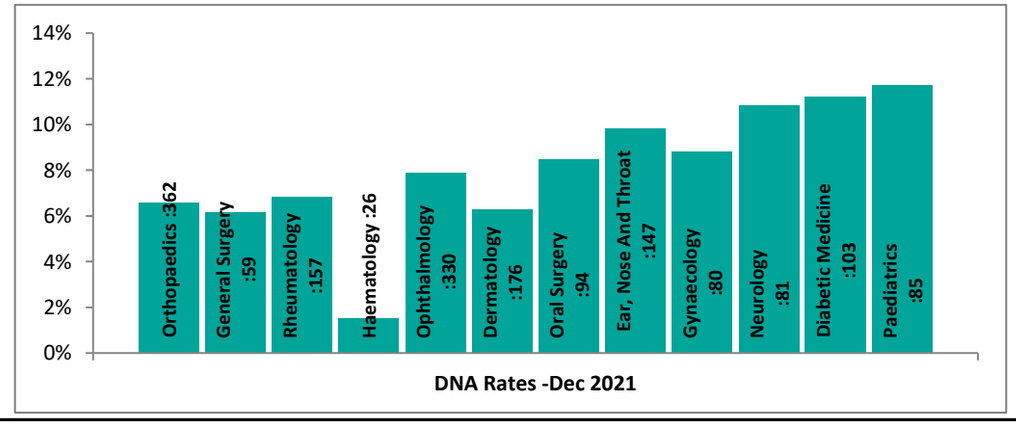
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on High Level Board Position

Bowel Cancer Screening

Invitation Backlog Recovery

Invitation backlog recovery achieved in May 2021.

The National Team have produced guidance to support programmes to adjust the invitation rate to enable the smoothing of peaks in invitations created during recovery through higher than normal levels of inviting. The current performance standard is +/- 6 weeks from invitation due date, the new guidance will allow for up to + 14 weeks. Additional flexibility with this standard will enable the programme to manage spikes in demand in 2023.

Dorset Plan to be agreed at Programme Board in January 2022.

Age Extension

Age extension was launched in May 2021 with invitations to 56 year olds and the bowel scope cohort. The team are preparing to invite 58 year olds in 2022/23 as part of the phased roll out and submitted plans to Commissioners in December 2021.

Key Performance Standards

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

The average uptake rate is 75% since January 2021 (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% for the last 18 months via virtual clinics (acceptable performance = 95%; achievable performance = 98%). Discussions are now taking place to restart some face to face clinics where need demands.

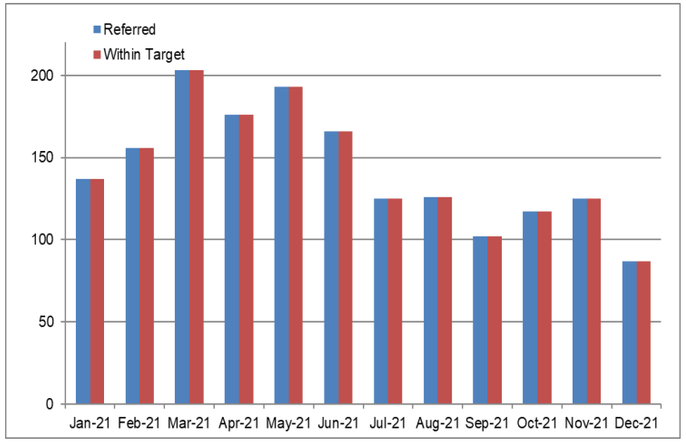
*** Diagnostic Wait Standard** *(Proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)*:

Diagnostic wait performance has been above the achievable standard of 95% between April and December 2021 (acceptable performance = 90%; achievable performance = 95%). There was a drop in performance to 93% in September due to colonoscopy and CTC capacity . However, this is still above the programme achievable standard. In December diagnostic wait performance was achieved at 99%.

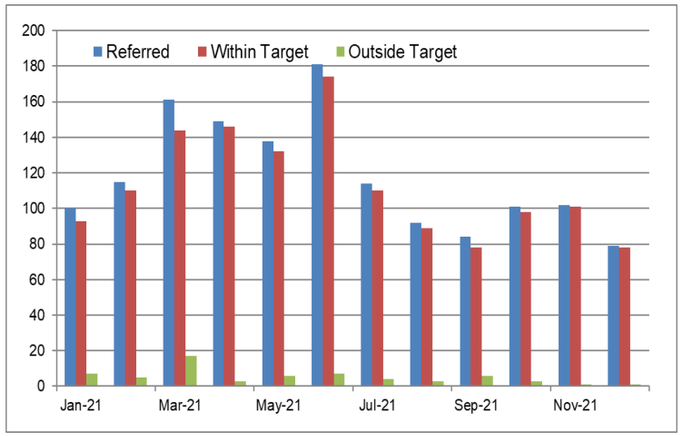
High Level Board Performance Indicators

Bowel Screening Standard	Target	Trust December Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	99%

Clinic Wait Standard



Diagnostic Wait Standard



SCREENING PROGRAMMES

Commentary on high level board position

Breast Screening

KPI's are being met with the exception of the Round length.

Significant staffing issues have forced a temporary revision of the recovery plan. There are not enough staff to continue at the current pace. The reduction is approximately 25%.

If the reduction continues at this rate the recovery would not take place until Autumn 2022 in the worst case scenario.

Locum Radiologist, bank staff and overtime continue to bolster capacity.

High level Board Performance Indicators & Benchmarking

Breast Screening	Standard	Merged Trust
Screening to Normal Results within 14 days	95.00%	99.00%
assessment appointment within 3 weeks	95.00%	99.00%
Round Length within 36 months	90.00%	34.00%
Longest Wait time (Months)	36	42

Maternity

Commentary

Midwifery staffing has remained challenging in December, due to workforce gaps and the impact of Covid. Some maternity services needed to be reduced for a short period of time (such as home birth service) to mitigate the risk and maintain safety.

An Implemtation plan to move to a new maternity digital system is planned for February which will enable women to have a personailsed care .

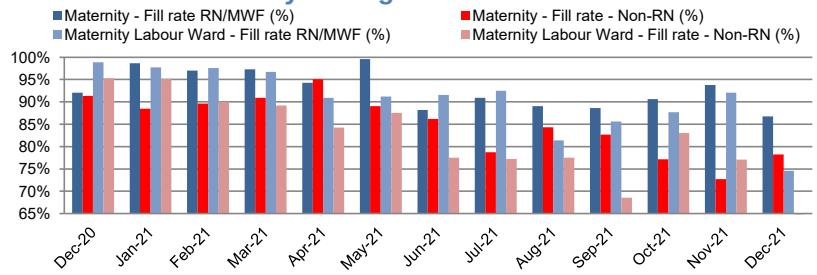
Delays in induction of labour is currently on our risk register - a working party commenced to improve our service with updating information to service users.

Continuity of care project plan will be prsented to the board to support implementation.

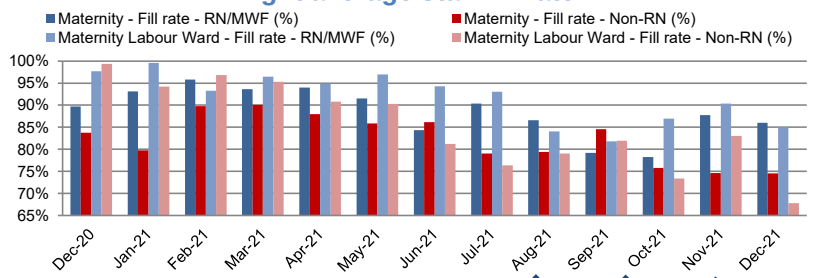
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Outstanding	Good	Outstanding

Screening incidences		2	
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	Good / Very Good	90%	
	Poor / Very Poor	5.40%	
	Neither	1.60%	
	Don't Know	3%	

Day average staff fill rate



Night average staff fill rate



Training Compliance PROMPT Dec 2021

	Number Compliant December 2020 to date	Number of Headcount Staff @ December 2021	Percentage Compliant
Midwives Band 5	13	18	72.2%
Midwives Band 6	119	168	68.7%
Midwives Band 7	20	30	66.6%
Midwiifery Managers, Matrons &Other Band 8+	5	7	71.4%
Consultant Obstetricians	13	17	76.4%
Obstetric Trainees (Doctors)	17	25	68%
Obstetric Anaesthetics	11	27	40.7
HCAs/MCAs/MSWs	31	78	39.7%
ODP	8	13	61.5%

Maternity

Severe Incidents (0)

HSIB Referal case (0)

Screening Incidents (2)

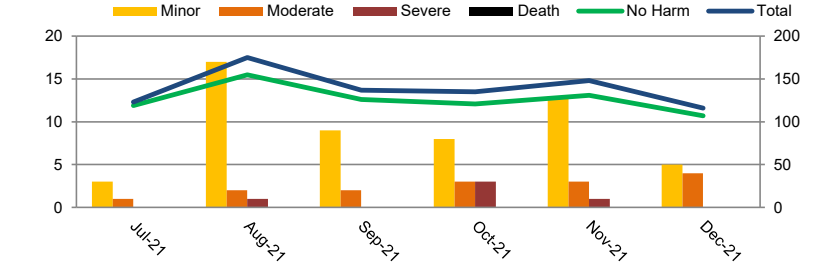
Perinatal Mortuary Review Panel (1 case reviewed)

Learning

Screening and Fetal Medicine team to consider to generically offering PAPP-A as a single screening test if patients decline chromosomal screening.

PMRT- Patient feedback regarding external entrance to Spring Suite is unwelcoming, including position of trade bins to the entrance and parking spaces. Spring charity to support improvements.

Datix Incidents



No Harm	119	155	126	121	131	107
Minor	3	17	9	8	13	5
Moderate	1	2	2	3	3	4
Severe	0	1	0	3	1	0
Death	0	0	0	0	0	0
Total	123	175	137	135	148	116

Learning from incidents

Learning from obstretric and a gastric cancer patient review

Recommendations

- Education of Obstetric and Midwifery staff regarding rarer causes of vomiting and weight loss in pregnancy and when to refer to gastroenterology services
- Consideration of endoscopic ultrasound at an earlier stage in cases of unclear diagnosis.
- Updating of Trust Protocol for the Management of Hyperemesis Gravidarum to give additional guidance on identifying alternative causes of nausea and vomiting in pregnancy, with appropriate referral pathways
- Open communication with patients regarding possible diagnoses and diagnostic uncertainty.

FINANCE

FINANCIAL INDICATORS	Year to date Budget £'000	Actual £'000	Variance £'000	Forecast Variance £'000
Control Total Surplus/ (Deficit)	1,425	1,470	45	528
Capital Programme	43,111	32,297	10,814	12,860
Closing Cash Balance	72,010	75,376	3,366	10,216
Public Sector Payment Policy	95%	91%	-4%	0

Commentary

The Trust set a breakeven budget for the second half of the year (the 'H2' period to 31 March) supported by the continuation of national top-up funding and funding to cover specific COVID costs. The national financial framework during this period includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. This is accounted for on a monthly basis, reported as a variance against both expenditure and income budgets. The full year deficit budget of £528,000 reflected the shortfall in ERF income received in the H1 planning period however this has now been fully funded through ERF+ resulting in a forecast breakeven position for the financial year ending 31 March 2022.

At the end of December, the Trust is reporting a £45,000 variance ahead of plan due to the phasing of ERF+ funding. Additional expenditure of £11.178 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been matched in full. Within this aggregate position, the Surgical Care Group report an adverse variance of £1.436 million, mainly due to CIP performance, additional medical staffing costs and partially offset by reduced activity particularly within Orthopaedics; the Medical Care Group report an adverse variance of £157,000, mainly due to an over achievement in cardiac private patient income together with the cessation of Bowel Scope and Bowel Cancer screening services; and the Specialties Care Group report a favourable variance of £1.093 million principally due to vacancies within Pathology and Pharmacy.

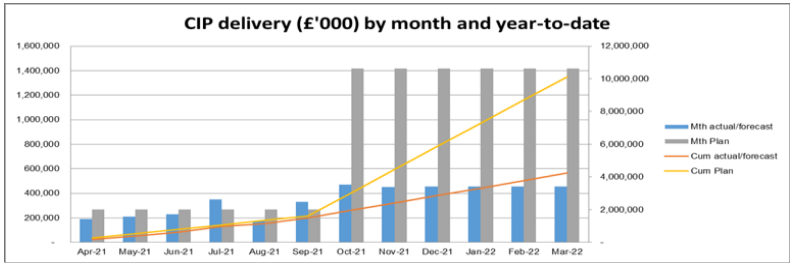
Cost savings of £2.869 million have been achieved to date against a target of £5.870 million, representing an under achievement of £3.001 million. Full year savings of £4.241 million have currently been identified of which 80% is non-recurrent. The refreshed H2 budget includes a significant increase in the savings requirement to £10.124 million for the full year, which if not achieved recurrently will result in further and considerable pressure on future years budgets. Currently the Trust is forecasting to deliver a shortfall of £5.884 million and a recurrent shortfall of £9.267 million.

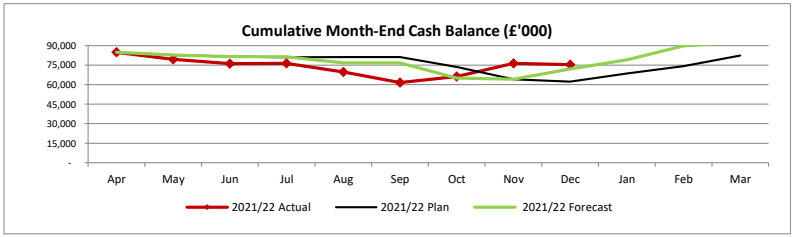
The Trust has set a very challenging capital programme for the year, with many priority schemes deferred due to the restrictive capital allocation for the Dorset Integrated Care System. This presents a considerable risk for the Trust and requires very careful ongoing management. As at 31 December capital spend is £32.297 million, being £10.814 million behind plan. This largely relates to underspends in the Maternity Children Emergency Centre and the Theatres Programme (STP Wave 1).

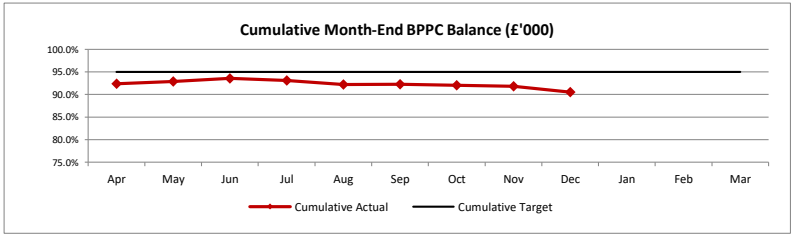
The Trust is currently holding a consolidated cash balance of £75.376 million, which is fully committed in support of the medium-term strategic reconfiguration programme.

REVENUE	Year to date Budget £'000	Actual £'000	Variance £'000
Surgical	(99,536)	(100,972)	(1,436)
Medical	(121,598)	(121,755)	(157)
Specialties	(129,191)	(128,098)	1,093
Operations	(19,681)	(19,034)	647
Corporate	(47,996)	(47,729)	266
Trust-wide	418,683	418,906	223
Surplus/ (Deficit)	**681**	**1,319**	**638**
Consolidated Entities	225	310	85
Surplus/ (Deficit) after consolidation	**906**	**1,629**	**723**
Other Adjustments	519	(159)	(678)
Control Total Surplus/ (Deficit)	**1,425**	**1,470**	**45**

CAPITAL	Year to date Budget £'000	Actual £'000	Variance £'000
Estates	12,725	14,217	(1,493)
IT	1,458	1,474	(16)
Medical Equipment	1,987	3,590	(1,604)
Donated Assets	783	1,588	(804)
Strategic Capital	26,159	11,428	14,731
Total	**43,111**	**32,297**	**10,814**





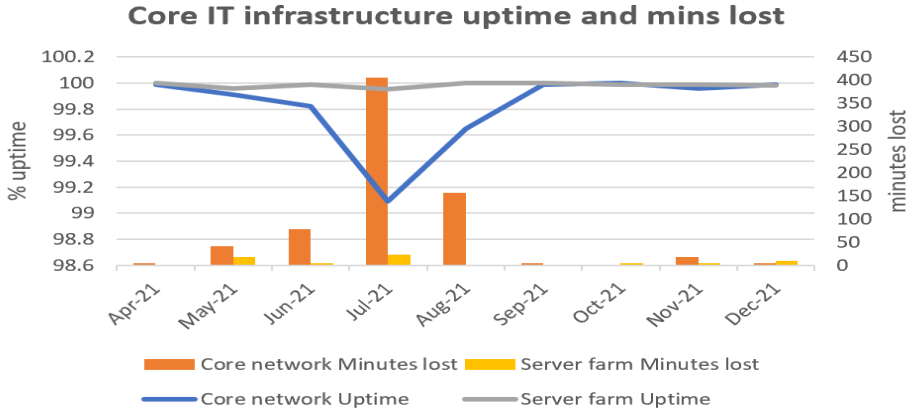


Informatics - Jan 2022

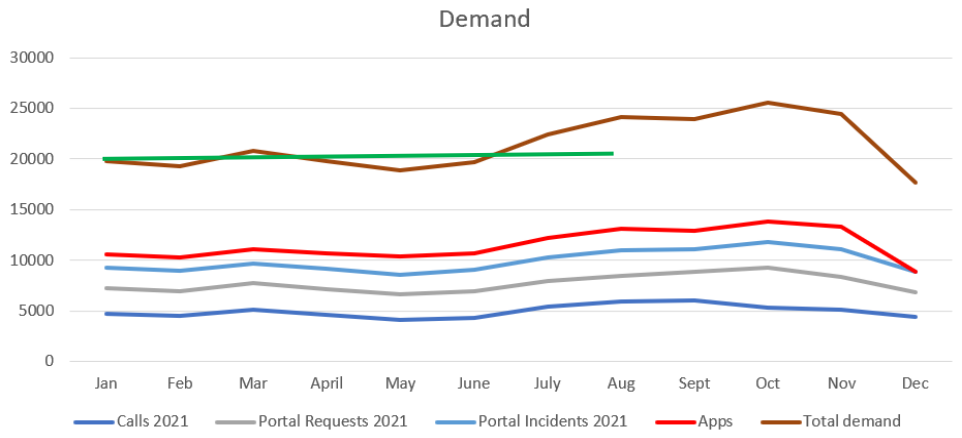
Overall Commentary: Graph 1: Sustained high performance of core infrastructure uptime**. Graph2:** understandable reduction in demand over the Christmas period. **Table 5:** Our Cyber programme has now reduced the unprotected servers to less than 2%. **Graph 6:** The steep acceleration of the number of Information Assets that are now compliant to the DSPT continues (green line)**. Graph 8:** DCR use continues to grow with more than 61,000 records accessed in Nov which was sustained in Dec (even with a shorter month). Other highlights: **Single Sign On:** Over 5700 users now live and 73 applications profiled.

Business As Usual/Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



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	2	13	15	36	173	237
Infrastructure Mandatory	0	20	0	4	5	29
Projects	1	48	18	94	271	431
Service Improvement Projects	0	0	0	0	3	3
Grand Totals	**3**	**81**	**33**	**134**	**452**	**700**

Table 4: Project Totals and Escalation

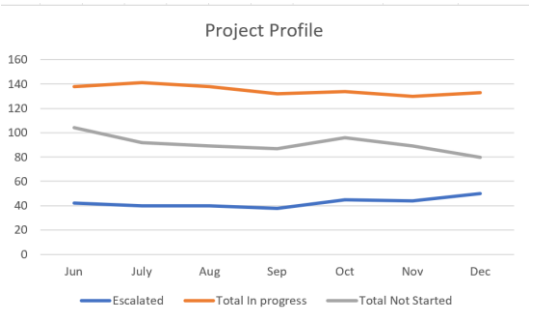


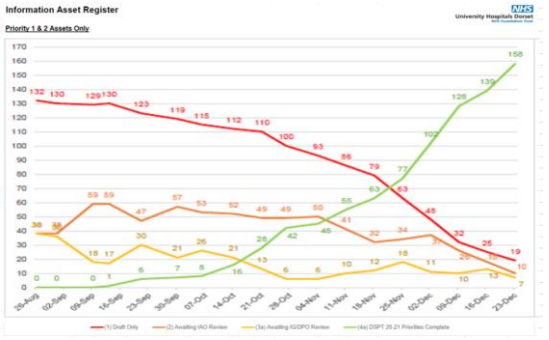
Table 5: Cyber Security - Obsolete system

	% Supported	% Obsolete	% Mitigated	% Unprotected
Windows Desktops	97.9%	2.1%	0.0%	2.1%
Windows Servers	71.0%	29.0%	27.8%	1.2%

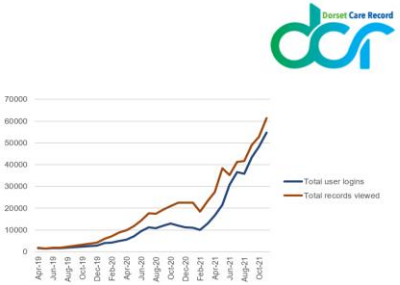
Table 7: FOI compliance

	Total rec'd	Compliance
August	50	82%
September	39	87%
October	36	64%
November	50	72%

Graph 6: Information Assets



Graph 8: DCR growth



BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 26 January 2022

Agenda item: 7.3

Subject:	Winter 2021 preparedness: Nursing & midwifery safer staffing

Prepared by:	Fiona Hoskins, Deputy Chief Nursing Officer
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	This paper details the preparedness of nursing and midwifery for safer staffing in Winter 2021 using an assurance framework to identify key actions
Background:	NHSEI published the Staffing Assurance Framework for winter 2021 in November 2021, for Trusts to complete in preparation for winter pressures and any future pandemic surges.
Key points for Board members:	To note; this paper has not been through the Workforce Strategy Committee yet, but it has been passed to the Non-Executive Director lead for this committee and Chief People Officer prior to Board. It will be presented at the next Workforce Strategy Committee. The board is asked to note the process' set out in the paper with regards to maintaining safe staffing.
Options and decisions required:	This paper is for assurance purposes.
Recommendations:	No recommendations
Next steps:	The paper will be taken to the Workforce Strategy Committee.

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:	Safe, Effective, Well Led.

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

1. Introduction

The Care Quality Commission (CQC) recognises the nursing workforce is facing acute pressures because of the pandemic, in particular decisions around nursing, midwifery and care staffing capacity and capability.

The CQC identified Trust boards members are collectively responsible for workforce planning, practice and safeguards and expect staffing decisions to be made with a focus on mitigating merging risks and trends using available resources responsibly and effectively.

This Assurance framework – nursing and midwifery staffing, builds on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

2. Assurance framework - nursing and midwifery staffing

On 12 November NHSEI published the Staffing Assurance framework for Winter 2021 preparedness with a focus on:

- Planning
- Decision making and escalation
- Staff training and wellbeing
- Indemnity and regulation
- Governance and assurance

A review of the framework, mapping UHD's position and required action is detailed in Table 1.

3. Recommendations

The Workforce Strategy and Development Committee are requested to note this report which is provided for information and assurance.

It is important to note that the whilst the Trust has a Red Flag and Critical Staffing Escalation Policy, to date the critical staffing elements of this policy have not been enacted

Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
1. Staffing Escalation / Surge and Super Surge Plans							
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches	The Red Flag and Safe Staffing Escalation policy written in January 2021 sets out the Trusts standard approach to managing safe staffing challenges from a day-to-day to extremis levels. Including clear trigger points for staffing from good to critical.	The policy includes: - modified care plans - safety briefing tool -guidance for care adjustments -SITREP reporting and post incident review process -Safe deployment of non-clinical staff to support care delivery. The policy has been enacted and amended in response to user feedback. Staff supporting critical care and working in environments outside of their usual field of experitise have received additional training.	**8 (2 x 8)**	The safe staffing plan requires on-going monitoring as the winter pans out as it is a responsive plan designed to offer options to suit a variety of situations.	In December 2021 a request for mutual aid for critical care from the MACA was submitted through Gold. Unfortunately, at the time this was declined. A further request for the MACA to be applied for	Usually through safe staffing, workforce and matrons' meetings.

	for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance		Staff supporting critical care with additional training. Skills to be added to staff profiles on Health roster for future reference and potential deployment in extremis.			the SW was submitted in January 2022 and declined, due to prioritisng support to areas with greater need. Plans for mutual aid from across the ICS have been worked up and agreed. A MOU to support ICS working is in train and expected to be signed off early in 2022.	
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised	As referenced in 1.1 the policy is constantly under review with changes captured within version of control of the document.	The policy has been written to incorporate current practice and procedures as much as possible.	**12 (3x4)**	The latest version of the policy updated for wave three of the pandemic has been consulted on and is currently	The pandemic staffing plan for UHD has been shared with system partners.	As set out in 1.1 the policy and its implementation remain under review

	version in preparation for winter				going through ratification		
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	The policy was piloted in several clinical areas prior to final ratification. The policy was passed through staff side before final sign-off in the spring of 2022. A staff side representative is on the HR Cell as part of Covid-19 response for wave 3 and is appraised of proposed changes as they occur.	The policy and its content have been widely escalated to all staff. As the policy is closely linked to business as usual all staff are familiar with the escalation steps. Ward teams are familiar with plans to reduce ward workload, however when running at threshold level there has been no requirement to implement this. This is achievable for short periods of time, however in sustained periods of pressure reductions in care workload will be required. No incidence of harm reported related to threshold staffing levels.	**4** **1x4**	Regular staff updates and reminders of the plan to be cascaded out to teams as part of incident preparedness.	The pandemic plan has been widely shared with external partners.	As set out in 1.1 the policy and its implementation remain under review
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles	A QIA is incorporated into the annual establishment review process that is signed off by the CNO. All significant adjustments to nursing templates occur through	The review process is reflected in the Establishment Review Policy. There is a three-tiered review process at ward, care group and executive level prior to final sign off by the CNO. All actions in tactical are captured in the tactical log. Due to	**12** **(4X3)**	In critical incident administrative support to the tactical team is essential to support completion of governance		Trust Gold, holds the tactical silver level to account for the completion of relevant risk

	(including base staffing levels) and this is signed off by the CN/MD	the tactical team in extremis and the care groups at other times. For all changes a Quality Impact Assessment is undertaken. As part of tactical response all proposed changes in clinical areas speciality or function require a QIA which is submitted to gold for approval.	responsiveness, there may be incidents where in discussion with gold a change is made with knowledge of the impact but prior to formal completion of the documentation.		paperwork robustly.		assessments / QIAs.
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and	Save staffing process' are set out in the Red Flag and critical escalation policy. Escalation is overseen by senior nursing staff in hours and clinical site team out of hours. The Trust heatmap for staffing provides transparent and visible oversight to safe staffing and is used in conjunction with Safecare allowing live oversight of workload against templated numbers.	Key aspects of the Trusts approach include: Staffing Huddles at Directorate level held daily. Twice daily Trust wide staffing meetings provide oversight of staffing levels and review/mitigation plan of areas at risk. Temporary staff bank engagement at meetings to support staffing shortfalls.	**2 (2x1)**	Currently a corporate risk assessment for staffing in development, nearing completion. This risk assessment will report current risk and provide a short-term forecast using capacity and absence rates to predict future state. The aim is for the	Current staffing shortages have been escalated to through to the ICS.	Staff shortages are monitored daily through the corporate safe staffing practices as set out in Assurance.

	where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze	During critical incident safe staffing is on the tactical agenda.			staffing risk to be reported daily to gold.		
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	All rosters are subject to an approval process, as per Trust policy. Twice daily staffing meetings include a 'look ahead' of staffing. Safe Care on Healthroster used to manage and monitor patient acuity and staffing requirements. In a critical incident the staffing hub will undertake forward planning and escalation of concerns. The Trust Covid dashboard sets out staff absence rates and is used to inform predicting impact of staff absence on the rosters.	Staffing Review Policy. Red Flag & Safer Staffing Policy. SOP for Incentivising hard to fill shifts with use of temporary staff. E Roster policy is used to standardise practice and improve roster efficiency, minimising gaps in rosters and forward planning staffing requirements. Staff movements are captured on the heatmap in Microsoft teams on the redeployment sheet.	3 **(1x3)**	A new safe staffing risk assessment tool has been developed and is being ratified currently, this includes forward planning. Standardise KPI's for E rostering and monitor compliance with the policy. Provision of Safe care training for new staff and managers to improve		Through the workforce cell and more formally the workforce strategy committee.

					compliance.		
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs	The Trust uses a written and verbal handover process to ensure that care requirements are clear and deliverable. Each ward has a written handover log for all patients capturing care requirements. All wards use Health of the ward regarding care requirements and next steps. The Clinical Site Team also support assessing patients' suitability for a placement. Healthroster record of staff skills and competencies Bleep and Board holders routinely check-in with the nurse in charge around safe staffing.	In the event of a patient being in an area where the nursing team feel their care requirements are challenging a Datix is filled in. The Trust has evidence of completion of these documents. Patients whose condition deteriorates are often seen by the outreach team whose data is used in overseeing patient placement and providing feedback. Staff training records are held centrally and overseen as part of corporate reporting and appraisal.	**2 (1x2)**	On-going discussion at staffing meetings around skill set against acuity in clinical areas.		Regular conversations with the clinical leaders around safe staffing and actions to take in extremis are on-going.
2.4	Staff receiving the patient (s) are clear in	All patients are received into the clinical area by a registered nurse.	Our datix and site reports evidence that staff are clear on the processes to follow when	**3 (1x3)**	On-going discussion at staffing		Regular conversations with the

	their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over	All nursing staff receive both a verbal and written handover for the patients in their care. All nursing staff have access to Health of the ward. Through professional registration all nurses should be aware of their responsibilities around escalating concerns if unsure. Verbal handovers are used prior to transfer to ensure that care requirements are clearly set out with written handovers used to clarify details.	care requirements exceed available skill set in an area. At times of staffing shortfall, the Trust will use temporary staffing solutions. The trust staffing bank will only place nurses in areas where they are appropriately skilled. The largest proportion of our temporary workforce are form our own bank and therefore trained through in-house provision.		meetings around skill set against acuity in clinical areas.		clinical leaders around safe staffing and actions to take in extremis are on-going.
2.5	There is a clear induction policy for agency staff. There is documented	This is outlined in the Trust Induction policy Section 5.4 The policy is in place, however regular agency	The return rate of documented evidence needs improvement. This is reliant on the clinical supervisor submitting signed documentation with the worker on completion of induction.	**9 (3x3)**	Improve education on evidencing Induction. Include review of temporary		Corporate Bank Lead to audit extent of gap – i.e., completed and evidenced

	evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting	staff do not always require this and at times the paperwork is not fully completed. Partial achievement			staff induction delivery as part of clinical leader 1:1's. Undertake an audit of temporary staff induction practice. Better coordination with follow up to unreturned checklists, audit extent of gap Link with agencies to improve return rate		Local Induction
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's	Staffing review meetings provide opportunity for concerns to be raised, managed, and escalated. Outside of the staffing meetings escalation is through the bleep holders to the matrons or clinical site team out of hours.	Use of Safe Care system to identify acuity and dependency of patients and staffing ratio twice daily. Staffing Huddles within directorates to review local challenges and agree mitigation/escalation Use of professional judgement on	**3 (3x1)**	Utilisation of Safe care and completion of Professional Judgement requires a refresh for new staff and to align the practice across UHD post-		Red flag data is reported monthly to the Board via the IPR. Care groups report critical incidents to the Quality Committee

	scope of practice	Red Flags Policy details process for escalation.	Safe Care to detail actions taken to mitigate risks or narrative on unmitigated risks		merger		monthly including linked staffing levels. Safecare and Unify data is reported to the Workforce Strategy Committee bi-monthly.
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care	Red Flag Policy and Safe Staffing Escalation The daily staffing heatmap captures staffing escalations and concerns and provides rationale for actions taken to respond to staffing levels. All Red Flags that are raised for safe staffing are captured in Safe Care and reported to the Workforce Strategy Committee and Board through the corporate Integrated Performance	The reporting of Red Flags on SafeCare on the Poole Hospital site is well established in practice. The use of SafeCare for Red Flags is new to the Bournemouth site and still embedding in practice. There is some inconsistency in embedding the new corporate Red Flag process across both sites. There is evidence of different risk level appetites around applying Red Flags against acuity.	**9 (3x3)**	The newly recruited workforce lead will be leading a project on embedding safecare across the Trust and ensuring consistency in practice.		The embedding of using safecare for red flag monitoring will be over seen through the IPR and workforce metrics. All Bournemouth site Datix for red flags (the old system) are

		Report.					reviewed and responded to.
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care	In response to the challenges of the pandemic the Trust is embedding a well-being model with clear stages of support from self / colleague support to formal psychological support when needed. As part of this work the UHD responder programme is currently being rolled out in support of self / peer / management help. The Trust has embraced the Professional Nurse Advocate roll, with three qualified and a further 15 expected to qualify in February. Policies to support staff to feel safe at work include, Occupational Health, Infection control practices, Human resources policies, Risk and Governance.	Freedom to Speak Up Guardian with a network of champions The Trust encourages staff to report near misses through the LERN process and our #sharetocare campaign. The Trust also runs wellbeing and employee assist services that staff can access for a breadth of information covering health, wealth, and welfare.	**6 (2x3)**	On-going embedding and cascading of information regarding available resources to teams.		

2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self-isolation, shielding, and those that are off sick. Leaders and board members therefore, have a holistic understanding	Electronic rostering (E-rostering) is fully established in all clinical nursing teams across the Trust. Pan UHD SafeCare data is now available and supports safe staffing by providing twice daily snap shots of patient acuity and dependency in a clinical area. This data is reviewed at the staffing meetings and enables informed decision making around staffing requirements and deployment. The use of the Heatmap at staffing meetings allows for conversations around professional judgement and balancing of staffing risks more widely. The Trust has a dedicated Covid dashboard highlighting sickness levels and enabling short-term forward planning.	Current practice across the three sites varies slightly but all rosters are well managed with only minor differences around roster rules 6 monthly safe staffing paper presented to Workforce Strategy Committee	**4** **2x2**	A new UHD E-rostering policy is being written and will include best practice standards including identifying a maximum number of shifts in accordance with whole time equivalent (WTE).		Staffing levels are monitored through the IPR and workforce matrices.

	of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach	Red flag reporting is in place. Datix incident reporting FTSOS Champions Psychologist in Critical care Schwartz Rounds Listening events Our communications team also monitor our social media platforms and escalate any concerning posts for action / checking in.	The Trust regularly receives red flags and datix forms around safe staffing. Unmitigated red flags become datix reports. All datix are investigated and reported.	**4 (2x2)**	A process for capturing locally led (departmental) well-being actions require development.		Staff access to wellbeing initiatives is captured and reported to the workforce strategy committee.

	team feedback etc) and learns from this intelligence						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes	During a critical incident the Workforce Cell is stood up. This a multiple disciplinary cell into which, OD, Education, Staff Side, Clinical Nursing & AHP feed their Hub information into. The Workforce cell reports directly into tactical on behalf of the hubs. The clinical Staffing Hub is chaired by the Deputy CNO Staffing reviews Policy enactment HR/Resourcing Meetings Monthly Safe staffing reviews with Matrons		**2 (2x2)**			

	of meetings						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold)	The Trust has a robust nursing leadership structure in place. At a care delivery level in the directorates all our nursing teams have a dedicated team leader or Matron overseeing the service. This Matron feeds into the daily Care Group huddles which manage and inform the Daily Staffing huddle. All clinical areas complete the staffing heatmap 24 hours in advance and the Eroster system collates Safe Care automatically allowing for good forecasting in advance. As referenced all staffing gaps and concerns are fed into the tactical group as regular agenda item.	Post-merger a clear senior nursing leadership structure has been embedded into both the corporate and care group structures this enables clear ward to board reporting through a dedicated nursing pathway.	**2 (2 x 2)**	Embedding of the new corporate risk assessment for declaring staffing risk and future risk		
3.3	The trust ensures system workforce leads and executive	As part of the winter resilience management process when an incident is stood up the executive team feedback corporate staffing challenges and	Red flag reporting to board is undertaken via the Chief Nursing Officer report to the Workforce Strategy Committee. Corporate oversight of temporary	**2 (2x2)**	on-going system wide engagement particularly in extremis when mutual aid may	There are on-going discussions around parity with regards to system risk.	

	leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients	requests into the system gold process. The Trust actively engages in system workforce programme with the CNO chairing the Dorset Nursing Workforce Group.	nursing workforce usage is undertaken at the non-medical clinical workforce TEG, which is chaired by the Chief Nursing Officer The Trust has Shelford Graduate Safe Staffing lead who connects regularly with the national team.		be required.		
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possible	The Trust uses several electronic systems to provide effective data around staffing risks. This includes: Eroster Safecare Corporate Heatmap	The Trust produces effective data around safe staffing levels reporting both locally and nationally. The corporate national safe staffing data benchmarks well against peer organisations.	**2 (2x2)**			On-going review and learning from unmitigated red flags and incidents.

	mitigate staffing risks to prevent harm to patients						
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks	The Trust reports safe staffing into the Workforce Strategy Committee alternate months via the Chief Nursing Officer Report. Safe Staffing metrics are included in the corporate IPR every month. Every six months the nursing directorate provides an assurance review report to both the Workforce Strategy Committee and Board.	Corporate oversight of temporary nursing workforce usage is undertaken at the non-medical clinical workforce TEG, which is chaired by the Chief Nursing Officer	**2 (2x2)**	The safe staffing risk assessment tool will provide both the current staffing risk and a future state risk. The tool is being piloted currently.		
4.2	Information from the staffing report is considered and	The Trust SI process includes robust investigations and staffing numbers on duty compared with acuity is	The Trust benchmarks well with regards to incident reporting levels and is assured that staff raise concerns appropriately.	**2 (2x2)**			

	triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process	considered as part of this. Reporting of SI's and patient outcomes is undertaken through the Quality Governance Group a multi-disciplinary group who considers all aspects pertaining to an incident - including staffing.	This work is also reviewed through the Quality Governance Group.				
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational	The Trust has a dedicated dashboard for COVID that always runs capturing all metrics from number of patients to staff absence. There is also an ICS dashboard that the Trust is connected to and utilises	This dashboard provides oversight of both patient and staff levels of Covid-19 and is used to gauge current and future operational position.	**2 (2x2)**			

	challenges						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making	Staffing reports are regularly presented to the Workforce and Strategy Committee. Through the IPR staffing levels are reported monthly to Board. In addition, the COO and CNO provide a dedicated Covid report to board.	The Board has approved the incident management structure and associated process'.	**2 (2x2)**			
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential	Staffing reports are regularly presented to the Workforce and Strategy Committee. Through the IPR staffing levels are reported monthly to Board. In addition, the COO and CNO provide a dedicated Covid report to board.	The Board has approved the incident management structure and associated process'.	**2 (2x2)**			

	exposure of patients to harm that may occur delivering care through staffing in extremis						
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges	The Trust is actively engaged in system wide response and solutions with many initiatives in place. These initiatives are reported to the Board via either the Quality, Workforce Strategy or Performance and Finance Committees either as bespoke reports or within Care Group Reports. For example: - The Care Hotel - Discharge initiatives.	System wide initiatives are discussed at the Clinical Reference Group which the CMO and CNO attend. The CNO attends the Dorset Quality Surveillance Group, where system wide risks and initiatives are discussed.	**2 (2x2)**			
4.7	The Board is fully sighted on the workforce challenges and any potential impact on	Safe staffing is reported to board via the workforce strategy committee and the IPR. Staffing risks are regularly reported to board.		**2 (2x2)**			

	patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic.	The board is informed of the Red Flag and Critical Staffing Escalation policy which sets out adjustments to care delivery and staffing parameters. The board is also informed of the consultation and development process of this policy. The Trust has formally documented its risk	Local leaders are actively involved in professional judgement decisions around safe staffing daily. This openly demonstrates the corporate risk appetite and challenge.	**2 (2x2)**			Open invitation for Board members to attend the safe staffing meeting for assurance.

	The risk appetite is embedded and is lived by local leaders and the Board (i.e., risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	appetite and there are discussions with the system regarding alignment of the policy to inform system wide decision making.					
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on	There are 5 Principle Board Objectives: To be a great place to work, by creating a positive and open and inclusive 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	The Board Assurance Framework has specific objectives related to Flow and Capacity, Operational, Staff wellbeing, Workforce and Partnership working. These are reported on the BAF.	**2 (2x2)**			BAF is reviewed at the Quality Committee and all other board sub committees. It is also overseen by the audit committee and reported to the Board of Directors.

	the Board Assurance Framework	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.					
4.10	Any active significant workforce	All increased risks over 12 are reported to the Board.	BAF is reviewed at the Quality Committee and all other board sub committees. It is also	**2 (2x2)**			

	risks on the Board Assurance Framework inform the board agenda and focus	All workforce risks (any grade) are reviewed by the Workforce Strategy Committee.	overseen by the audit committee and reported to the Board of Directors.				
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	The CNO attends weekly calls with the regional Chief Nursing Officer and therefore the CNO is appraised of the regional and national impact of the pandemic. The CNO also has a regular programme of engagement meetings with the CQC, and part of this focus is regarding safe staffing as a fundamental standard.	The Red Flag and Critical Escalation Policy has been shared with the regional NHSE/ I team and the CQC. To date there have not been any incidents where critical staffing or appendix 11 have been required to be escalated.	**2 (2x2)**			

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 26 January 2022

Agenda item: 8.1

Subject:	Continuity of Carer Implementation Project Plan January 2022

Prepared by:	Lorraine Tonge, Group Director of Midwifery
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	The implementation plan outlines the investment workforce and the training required to up skill the workforce and the timeframe for change.
Background:	Maternity Services in England have been undertaking maternity transformation since the publication of Better Births in April 2016. Under the maternity transformation and maternity incentive scheme there is the expectation to achieve continuity of carer. Guidance was published in October 2021 to implement a full scale change in all maternity units. Continuity of carer is a new model of care where care is provided by a small team of 6-8 midwives who will provide antenatal, labour and postnatal care. UHD midwives have provided a traditional care model so transformation is a significant change for the midwifery team and will require- training time, equipment, and different ways of working, with financial investment to make this transition safely.
Key points for Board members:	The Continuity of carer model is part of the maternity incentive scheme and safety agenda. This needs to be implemented as the default model. The project plan outlines the planned time-frame, financial investment and building blocks which need to be in place to implement safely at UHD.
Options and decisions required:	Endorsement is required by the Trust Board to support this plan, which will then be submitted to the LMNS and Regional Chief Midwife Helen Williams.
Recommendations:	For endorsement
Next steps:	As outlined above

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	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
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Safe, effective, responsive, caring, well led

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

Trust Board Summary paper

Continuity of carer

Implementation Project Plan

January 2022

Lorraine Tonge Care Group Director of Midwifery

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Introduction

Maternity Services in England have been undertaking maternity transformation since the publication of Better Births in April 2016.

Under the maternity transformation and maternity incentive scheme there is the expectation to achieve continuity of carer.

Guidance was published in October 2021 to implement a full scale change in all maternity units.

Continuity of carer is a new model of care where care is provided by a small team of 6-8 midwives who will provide antenatal, labour and postnatal care.

UHD midwives have provided a traditional care model so transformation is a significant change for the midwifery team and will require- training time, equipment, and different ways of working, with financial investment to make this transition safely.

The implementation plan outlines the investment workforce and the training required to up skill the workforce and the timeframe for change.

Reason for Change

Continuity is part of the safety agenda as evidence shows that there is:

1. 16% less likely to lose their baby before & after 24 weeks plus neonatal death
2. 19% less likely to lose their baby before 24 weeks
3. 15% less likely to have an epidural (regional analgesia)
4. 24% less likely to experience preterm birth
5. 16% less likely to have an episiotomy
6. 10% less likely to have an instrumental birth

Method of Approach – Building Blocks

The guidance in October 2021, NHSE recognised the challenges of the midwifery workforce and all plans need to put building blocks in place to implement safely.

The building blocks which need to be completed prior to roll out of continuity of carer teams safely are:

Safe staffing

To transform the service we need to ensure that Midwifery staffing levels are safe and therefore a full scale recruitment campaign is required.

Additional midwives required as per birth-rate plus and along with our current vacancies

(23 WTE midwives need to be recruited) .

Training

Each Midwife will be required to meet with the Practice Development Team to discuss their training needs and put together an individualised training needs analysis (TNA) dependent on their level of knowledge and experience and will have a list of competencies to achieve which are required for their new way of working. Funding will be required to support this training.

On-going training will need to be maintained for all staff. Therefore there will be a need to increase the training uplift for all midwives and this reflected in the maternity budget.

Midwifery Pay

An agreed method of payment will need to be considered prior to commencing the first team. The RCM requests that no Midwife should be financially disadvantaged for working in this way, there are different options for pay including on call rates and uplifts.

Estates

Work is being undertaken currently to maximise clinical space for maternity outpatient services. The continuity model can be delivered in our new build.

Equipment

Each Midwife will be required to carry individual equipment. Each team will have this initial start-up cost. (The costing for each wave is included in the financial appraisal.)

Skill Mix

An important part of workforce planning when converting into continuity teams will be skill mix and appropriate placement of band 5 Midwives and maternity support workers will be considered.

Communication and engagement

Staff engagement has taken place across the trust in different formats, including at clinical leaders meetings (band 7 and 8 Midwives), at clinical governance meeting (obstetricians and Midwives), drop in engagement events for all staff, teams engagement event including guest speaker. Initial feedback is that not all midwives wish to work in this way however around 10% would favour this way of working.

Communication events will continue throughout implementation and working with staff and our HR department.

Linked Obstetrician

Each team will have a linked obstetrician; they will not necessarily be the lead obstetrician for all women cared for by that team as they all have different areas of expertise within obstetrics. They will however be available to the Midwives in their team to ask questions and advice and also to attend team meetings to discuss cases and offer their input.

Standard operating procedure (SOP)

SOP's will be developed and shared with Midwives and Obstetricians outlining the new ways of working.

Team Building

When setting up each team, Midwives will be encouraged to take part in team building exercises to help strengthen the teams and keep them working towards a shared goal. Advice will be sought from the organisational development team within the trust who have specific training and skills to develop teams. This time will need to be incorporated into their normal working hours once the team has started and the caseloads are being built up.

Evaluation

There is a requirement to report data nationally via the MSDS systems. Reporting systems are in place on the current maternity system 'Medway' and the future maternity system 'badgernet'.

There will also be reporting data requirements through the LMS and Regional teams.

Review process

The workforce will be reviewed before each wave of teams are introduced and if it is not at establishment then recruitment will be prioritised and the teams will be delayed until such a time when safety can be ensured. The effectiveness of the teams in place will also be reviewed after each wave using the PDSA approach.

WE plan to target those most venerable and the place to start when looking at introducing a continuity team is to target the women who will benefit from it most.

Timeline

The implementation to a full scale model will take several years to achieve for UHD.

2022 will focus on a recruitment campaign

2023 will implement the first team for vulnerable women and evaluate.

2024 Implement 2nd and 3rd team and if successful

2025 Will implement 4 and 5th team

A total of 17 teams are needed to achieve full scale.

Financial Appraisal

The cost of transition will be over several years outlined in the financial appraisal is the

Total for one team	78,221.32
Total for 17 teams	1,329,762.44

Improvement of safety cannot be financially reflected however a safer maternity unit will reduce litigation and overall cost to the Trust.

Conclusion

The Continuity of carer model is part of the maternity incentive scheme and safety agenda. This needs to be implemented as the default model. The project plan outlines the planned time-frame, financial investment and building blocks which need to be in place to implement safely at UHD.

Endorsement is required by the trust Board to support this plan, which will then be submitted to the LMNS and Regional chief Midwife Helen Williams.

Reference

_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 26 January 2022

Agenda item: 9

Subject:	Sustainability Committee Terms of Reference Transformation Committee Terms of Reference Quality Committee Terms of Reference Board of Directors Governance Cycle

Prepared by:	Sarah Locke, Deputy Company Secretary Ewan Gauvin, Corporate Governance Assistant
Presented by:	Sarah Locke, Deputy Company Secretary

Purpose of paper:	To approve the 3 terms of reference and the governance cycle
Background:	Terms of Reference and Governance Cycles are brought to the Board of Directors for sign off.
Key points for Board members:	Sustainability Committee Terms of Reference Changes highlighted in red. This version has been updated to bring them in line with other UHD terms of reference documents. This document has been endorsed by the Sustainability Committee. Transformation Committee Terms of Reference Terms of Reference have been updated to reflect the changes to the members and the attendees. This document has been endorsed by the Transformation Committee Quality Committee Terms of Reference The Quality Governance Group has changed their title to Clinical Governance Group. This document has been endorsed by the Quality Committee. Board of Directors Governance Cycle Changes made on the months that the Freedom to Speak Up Guardian presents at the Board of Directors.
Options and decisions required:	For approval of all the documents.
Recommendations:	For approval.
Next steps:	Approved documents will be used for the ongoing governance of their respective Committees and will be reviewed annually or sooner as required.

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**
Sustainability Committee	13/12/2021
Transformation Committee	16/12/2021
Quality Committee	20/12/2021

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust (UHD)

Sustainability Committee

202**1 V1.2**

DOCUMENT DETAILS

Author:	Ewan Gauvin
Job Title:	Corporate Governance Assistant
Signed:	
Date:	~~July 2020~~December 2021
Version No: (Author Allocated)	1.2
Next Review Date:	December 2021~~1~~

Approving Body/Committee:	Board of Directors
Chair:	~~Board Chairman~~David Moss
Signed:	
Date Approved:	~~18 September 2020~~
Target Audience:	Non-Executive and Executive Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
August 4th 2020	1	In month		RR	New Document
August 19th	1.1	2021		RR	Amended Draft
December 2021	1.2	December 2022		FR	Document review

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	Chairman	Date	~~18 September 2020~~
Print Name	John Lelliot	Signature	
COMMITTEE APPROVAL			
If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of Committee	Board of Directors	Date	~~TBC~~
Print Name	David Moss	Signature	

		of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST ~~(UHD)~~

Sustainability Committee ~~(SC)~~

TERMS OF REFERENCE

1. PURPOSE~~CONSTITUTION~~

1.1 The Sustainability Committee ~~(SBC)~~ is a ~~formal~~ committee ~~reporting to~~of the the Board of Directors and has no executive powers other than those specifically delegated in these terms of reference.

1.2 The definition of sustainability is meeting the needs of the current generation without compromising future generations of the ability to meet their needs, in social, economic or environmental terms. UHD and the wider NHS are~~is~~ also assessing the health and wellbeing of the population for environmental changes, including the impacts of a warming planet, air quality and mitigations for these negative changes.

1.3 Specific areas of focus include ensuring a reduction in carbon, single use plastics and air pollution. The Committee will monitor progress on these areas through the Sustainability Steering Group. ~~The working groups to progress these are:~~

- ~~Energy~~
- ~~Waste~~
- ~~Transport~~
- ~~Procurement~~
- ~~Water~~
- ~~Staff leadership through environmental champions~~

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1.4 The Sustainability Committee~~C~~ is responsible for:~~-~~

i) Ensuring a clear and ambitious strategy is set for sustainability along with annual plans with SMART objectives.

ii) Reviewing the Trust's annual business plan and other strategies to ensure sustainability and mitigations to climate change is assured and embedded.

iii) Maintaining an overview of the progress towards the delivery of agreed strategies, and escalating issues as appropriate to the Board. This includes scrutinising the Board Assurance Framework with regard to the strategic risks relating to Sustainability.

iv) Reviewing the Trust's draft annual accounts and recommending to the Board of Directors, for submission to NHS Improvement and other regulators as appropriate on issues of sustainability, including carbon reduction and corporate social responsibility.

v) Receiving for scrutiny the quarterly report from the Sustainability Steering Group.

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~~iv)~~vi) Approving its Governance Cycle.

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2. MEMBERSHIP

2.1 Membership of the ~~Group~~ Committee comprises three N~~n~~on-E~~e~~xecutive D~~d~~irectors, the Chief ~~of~~ Strategy and Transformation Officer, the Chief ~~of~~ Finance Officer and the Chief Executive Officer.
~~All appointments to the Group shall be made by the Board of Directors.~~

2.2 The ~~Group~~ Committee will be chaired by a N~~n~~on-E~~e~~xecutive D~~d~~irector of the Trust (not the Chair~~man~~ of the Trust), appointed by the Board of Directors. A N~~n~~on-E~~e~~xecutive Deputy Chair~~man~~ should~~may~~ be nominated. In the absence of the Committee Chair~~man~~ and/~~-~~or any appointed d~~D~~eputy, the remaining members present shall elect one of themselves ~~non-executive directors present~~ to chair the meeting.

2.3 ~~Members in attendance comprise of the Trust sustainability manager, the Director and Associate Director of Estates, and a representative from communications. An invite will also be made for Bournemouth, Christchurch, Poole (BCP) Council and Bournemouth University (BU) to attend. Other subject matter experts and leads for the working groups may be invited to attend as required.~~ In addition, the following will attend the Committee to provide information and advice with prior agreement of the Chair of the Committee and in the event that a report is presented to the Committee or a Chief Officer is unable to attend:

- Associate Director of Estates
- Trust Sustainability & Carbon Manager
- The Chair of the Sustainability Steering Group
- A representative from Communications
- A representative from Bournemouth, Christchurch & Poole Council
- A representative from Bournemouth University

2.4 Only members of the Committee have the right to attend Committee meetings. Any other directors may attend following notification to the Chair.

2.5 Any Non-Executive Director not appointed to the Committee may attend with the prior consent of the Chair.
~~The UHD Council of Governors will also be able to select and send an observer for the committee.~~

2.6 A nominated Governor may attend each meeting as an observer; observers are not members of the Committee.

3. FREQUENCY OF MEETINGS

3.1 The ~~Group~~ Committee will normally meet on a quarterly basis and at such other times as the ~~Group~~ Committee shall require.

4. NOTICE OF MEETINGS

4.1 The Committee shall be supported by the Company Secretary.

4.2~~1~~ Meetings of the Committee ~~Group~~ shall be called by the Company Secretary at the request of the ~~Group~~ Committee Chair~~man~~ or Chief Strategy and Transformation Officer.

4.3 The Committee Chair will agree the agenda and papers to be circulated with the Company Secretary or their nominee.

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4.42 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the ~~Group~~Committee~~, other Directors~~ and any other person required to attend, no later than seven~~7~~ working days before the date of the meeting.

5. QUORUM

5.1 The quorum of the ~~Group~~ Committee is at least three members and shall include no~~t~~ less than one non-executive director.

5.2 In the absence of a~~the~~ Chief Officer, as detailed in 2.1,~~s~~ a deputy (who is an invited attendee) should be present.

5.3 If the meeting is not quorate the meeting can progress if those present determine. ~~this.~~ However no business~~decisions~~ shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item. ~~, or these can be agreed via electronic means.~~

6. ACCOUNTABILITY

6.1 The ~~Group~~ Committee is accountable through the Board of Directors for reviewing all matters related to Sustainability.~~strategy and implementation~~.

7. RESPONSIBILITIES

7.1 The responsibilities of the ~~Group~~ Committee are set out in its Purpose~~Constitution~~ (see 1~~2~~.1) above and in its Governance Cycle.

8. AUTHORITY

8.1 The ~~Group~~ Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

8.2 The ~~Group~~ Committee is authorised to approve its own governance cycle.

8.3 The ~~Group~~ Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

8.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The ~~Group~~ Committee will receive any items for escalation from following Group: ~~committees / working groups:~~

- ~~Trust Management Group (TMG)~~
- ~~Transport~~

- ~~Energy~~
- ~~Waste~~
- ~~Water~~
- ~~Procurement~~
- ~~Pharmacy~~
- ~~Staff environmental Champions Committee~~ Sustainability Steering Group

10. REPORTING MECHANISM

10.1 The Chair~~man~~ of the ~~Group~~ Committee should draw to the attention of the Board of Directors any issues that require disclosure or further action.

10.2 The agenda will be agreed by the Chair~~man~~ of the Sustainability Committee~~C~~ in discussion with the ~~Chief of Strategy~~Chief Strategy and Transformation Officer and Company Secretary or their nominee.

10.3 The Agenda and Papers will be available ~~circulated~~ to all members of the Board of Directors on request.

10.4 A formal minute of the meeting will be recorded and these minutes will be available on request to the Board of Directors.

10.5 Action items will be recorded at each meeting and a log kept monitoring and reviewing progress. A review of the action log will be a standing item on each agenda.

10.6 The Committee~~Group~~ will provide an annual report on its work and how it discharges its responsibilities to ensure it is operating at maximum effectiveness and submit this to the Board of Directors.

10.7 The ~~Group~~ Committee will be supported by the office of the Company Secretary. Minutes will be recorded by the Company Secretary's office or appropriate alternative.

11. PROCESS

11.1 To review and make comment to the Board on the long term strategic plans for environmental sustainability.

11.2 To receive and review any reports prior to submission to NHS Improvement or other external regulators, where appropriate.

11.3 To review and scrutinise the Trust's draft Annual Report prior to submission to the Board for matters of sustainability, climate adaptation and carbon reduction, and related areas of corporate social responsibility.

11.4 Review relevant sections of the risk register and or Board Assurance Framework regularly and report appropriately regarding the sustainability agenda, including legal requirements, and good practice in terms of achieving environmental sustainability.

12. COMMUNICATION

12.1 The minutes of each meeting of the ~~Group~~ Committee will be formally recorded and submitted to the next meeting of the ~~Group~~ Committee for approval.

12.2 The annual report of the Trust will contain a section regarding the work of the CommitteeSC. There will also be a Green Plan reported annually to the Trust Board of Directors.

12.3 As there is widespread public, staff and partner interest in matters of environmental sustainability, the committee will also be for assurance that communicating the action and performance against this agenda, the future requirements and the wider need for changes in behaviour to protect the environment.

13. MONITORING

13.1 Attendance will be monitored as part of the agenda at each Committee meeting and a matrix (see Appendix A) of membership attendees will be used for monitoring purposes.

13.2 The Trust's Annual Report will include membership attendance, frequency of meetings and whether meetings were held in quorum.

14. REVIEW

14.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

14.2 The position of Chairman of the Group Committee will be reviewed at least every three years.

APPENDIX A

SUSTAINABILITY COMMITTEE MEETING ATTENDANCE RECORD

2020/21

NAME OF COMMITTEE:	Sustainability Committee											
REPORT TO :	Board of Directors											
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**											
	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**		
Was the meeting held in quorum? (Please refer to Terms of Reference) Y / N												

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust (UHD)

Transformation Committee

2021 V1.6

DOCUMENT DETAILS

Author:	Richard Renaut (RR)
Job Title:	Chief of Strategy and Transformation
Signed:	
Date:	September 2021
Version No: (Author Allocated)	1.6
Next Review Date:	October 2022

Approving Body/Committee:	Board of Directors
Chair:	Board Chairman
Signed:	
Date Approved:	26 May 2021
Target Audience:	Non-Executive and Executive Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
July 2020	1			RR	New Document
3 Aug 2020	1.1			RR	Feedback amendments
19 Aug	1.2	Sept 2021		RR	Final draft
28.10.20	1.3			RR	Minor amendments
05.11.20	1.4			RR	Appendix B added
26 May 2021	1.5	2022	26 May 2021	RR	Approved by Board of Directors
Sept 2021	1.6				

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INDIVIDUAL APPROVAL			
Job Title	Chairman	Date	26 May 2021
Print Name		Signature	
COMMITTEE APPROVAL			
If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of Committee	Board of Directors	Date	26 May 2021
Print Name		Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST (UHD)

Transformation Committee

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Transformation Committee (TC) reports to the Board of Directors and has no executive powers other than those specifically delegated in these terms of reference.

1.2 The TC is responsible for:

i) Establishing the strategy and methodologies for setting, monitoring implementation and assurance of benefits realisation for the Transformation agenda for the Trust, on behalf of the Board of Directors.

ii) The Transformation Committee scope covers benefits realisation of identified transformation objectives, including those defined in the merger business case including:

- The Patient Benefits Case (PBC) for merger
- Post-merger transaction implementation plans (PTIPs)
- Delivery of financial and non-financial benefits of merger integration and reconfiguration
- The Digital Transformation strategy, as part of Digital Dorset and UHD's own digital strategy
- The Quality Improvement strategy (QI)
- The Clinical Services Review (CSR) implementation
- Estates transformation with particular focus on delivery of the elective and emergency hospitals reconfiguration (delivered via P22 framework)
- Wider service changes and system level transformation in services.

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. MEMBERSHIP

2.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Executive, the Chief of Strategy and Transformation, the Chief Operating Officer, the Chief of Informatics and the Chief People Officer. All appointments to the Committee shall be made by the Board of Directors. All Board members can attend as required.

2.2 The Committee will be chaired by a Non-Executive Director of the Trust (not the Chairman of the Trust), appointed by the Board of Directors. A Non-Executive Deputy Chairman may be nominated. In the absence of the Committee Chairman and or any appointed Deputy, the remaining members present shall elect one of the Non-Executive Directors present to chair the meeting.

2.3 Members in attendance include the Director of Transformation, the Director of

Improvement and Integration and the Head of Productivity and Efficiency.

2.4 Others in attendance include a Council of Governors representative, on behalf of members and the public. Other attendees will be invited as required.

2.5 Committee membership in respect of the financial year 2021/22 comprises:

- 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

3. FREQUENCY OF MEETINGS

3.1 The Committee will normally meet on a quarterly basis and at such other times as the Committee shall require. Meetings scheduled for 2021/22 are on the following dates:

- 17th June 2021
- 16th September 2021
- 16th December 2021
- 17th March 2022

4. NOTICE OF MEETINGS

4.1 Meetings of the Committee shall be called by the Company Secretary at the request of the Committee Chairman or Chief Strategy and Transformation Officer.

4.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the Committee, other Directors and any other person required to attend, no later than 7 working days before the date of the meeting.

5. QUORUM

5.1 The quorum of the Committee is at least three members and shall include not less than one Non-Executive Director.

5.2 In the absence of the Chief Officers a deputy (who is an invited attendee) should be present.

5.3 If the meeting is not quorate the meeting can progress if those present determine this. However, no decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item, or these can be agreed via electronic means.

6. ACCOUNTABILITY

6.1 The Committee is accountable through the Board of Directors for reviewing strategy for transformation, implementation and benefits realisation in matters defined as transformation.

7. RESPONSIBILITIES

7.1 The responsibilities of the Committee are set out in its Constitution (see 2.1) above and in its Governance Cycle.

8. AUTHORITY

8.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

8.2 The Committee is authorised to approve its own governance cycle.

8.3 The Committee is authorised by the Board of Directors to obtain any external advice it requires to discharge its duties.

9. RELATIONSHIPS WITH OTHER GROUPS

9.1 The TC will receive reports and items for escalation from the following operational groups:

- Quality Improvement and Digital Group
- Reconfiguration Oversight Group
- Benefits Realisation Assurance Group
- P22 Board for the estates project
- Clinical Assurance Group

9.2 The Transformation Committee remit by its' very nature includes quality, costs, workforce and operations. For avoidance of doubt, whilst the Transformation Committee scope is as set out in 1.2 above, there will be close alignment with other Board committees, who have their primary role of assurance and oversight as per their Terms of Reference. These include:

- Quality Committee
- Finance and Performance Committee (including and operational performance, and approval of business cases)
- Workforce Strategy Committee
- Audit Committee

The Board of Directors will continue to provide oversight and the unitary Board approach, as well as setting the overall strategy for the organisation, and being accountable.

10. REPORTING MECHANISM

10.1 The Chairman of the TC should draw to the attention of the Board of Directors any

issues that require disclosure or further action.

10.2 The agenda will be agreed by the Chairman in discussion with the Chief of Strategy and Transformation.

10.3 The agenda will be circulated to all members of the Board of Directors.

10.4 A formal minute of the meeting will be recorded and items for escalation will be reported to the Board of Directors.

10.5 Action items will be recorded at each meeting and a log kept monitoring and reviewing progress. A review of the action log will be a standing item on each agenda.

10.6 The Committee will provide an annual report on its work and how it discharges its responsibilities to ensure it is operating at maximum effectiveness and submit this to the Board of Directors.

10.7 The Committee will be supported by the office of the Company Secretary. Minutes will be recorded by the Company Secretary's office, or appropriate alternative.

11. PROCESS

11.1 To review and make comment to the Board of Directors on strategic plans regarding the transformation agenda.

11.2 To receive and review any reports prior to submission to NHS Improvement or other external regulators, where appropriate.

11.3 Review relevant sections of the risk register and or Board Assurance Framework regularly and report appropriately for the transformation agenda.

12. COMMUNICATION

12.1 The minutes of each meeting of the Committee will be formally recorded and submitted to the next meeting of the Committee for approval.

12.2 The annual report of the Trust will contain a section regarding the work on transformation.

13. MONITORING

13.1 Attendance will be monitored as part of the agenda at each Committee meeting and a matrix (see Appendix A) of membership attendees will be used for monitoring purposes.

13.2 The Trust's Annual Report will include membership attendance, frequency of meetings and whether meetings were held in quorum.

14. REVIEW

14.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

14.2 The position of Chairman of the Committee will be reviewed at least every three

years.

APPENDIX A

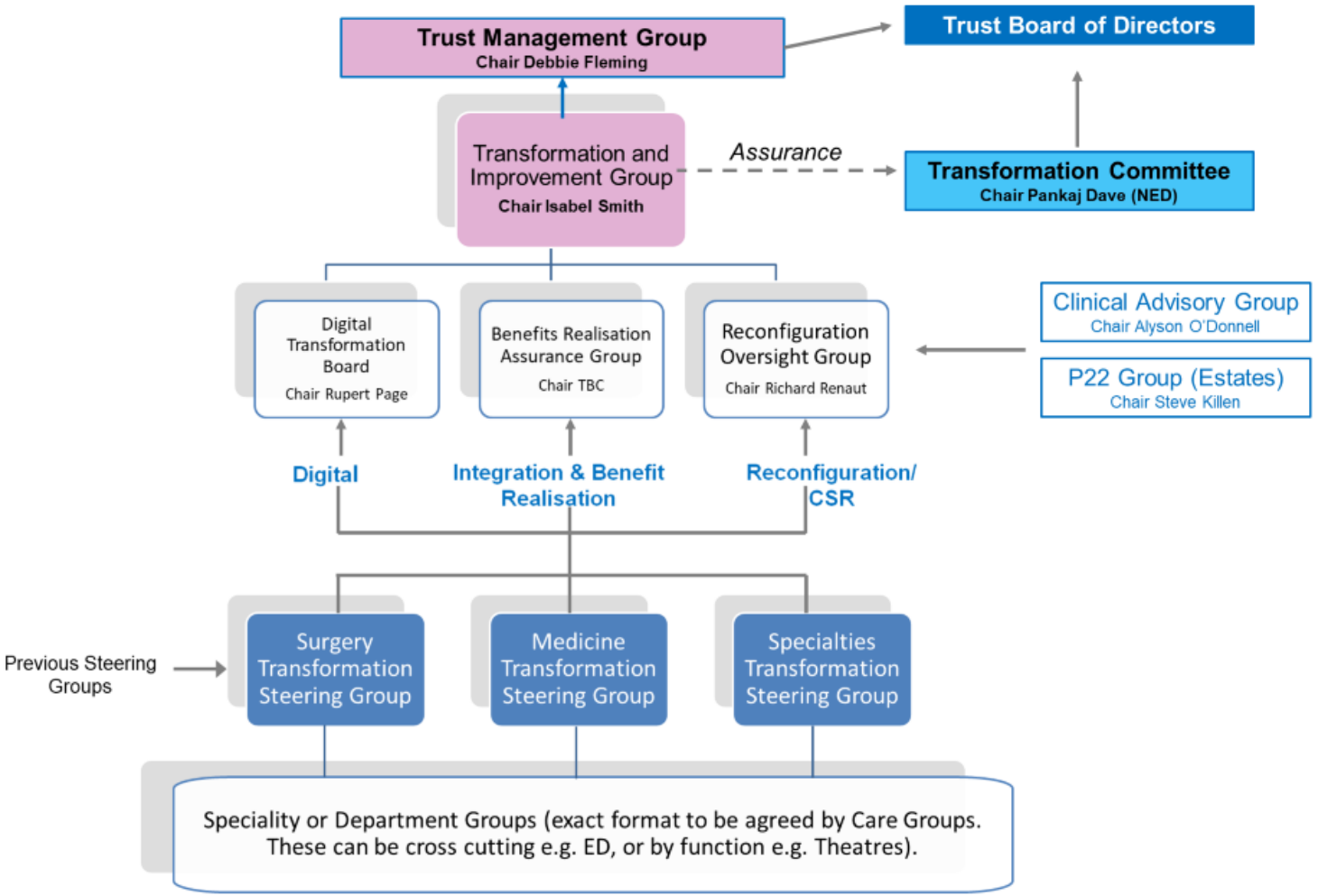
TRANSFORMATION COMMITTEE MEETING ATTENDANCE RECORD

2021/22

NAME OF COMMITTEE:	Transformation Committee											
REPORT TO:	Board of Directors											
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**											
	Quarter 1 June 2021			**Quarter 2 Sept 2021**			**Quarter 3 Dec 2021**			**Quarter 4 Mar 2022**		
Pankaj Dave	✓											
Cliff Shearman	✓											
Caroline Tapster	x											
Debbie Fleming	✓											
David Moss	✓											
Deborah Matthews	✓											
Karen Allman	✓											
Richard Renaut	✓											
Peter Gill	x											
Alan Betts	✓											
Stephen Killen	✓											
Michele Whitehurst	✓											
Mark Mould	x											
Was the meeting held in quorum? (Please refer to Terms of Reference) Y / N												

APPENDIX B

Transformation Governance



TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Quality Committee

~~October 2021~~January 2022

DOCUMENT DETAILS

Author:	Carrie Stone
Job Title:	Company Secretary
Signed:	
Date:	~~October 2021~~January 2022
Version No: (Author Allocated)	1.3~~2~~
Next Review Date:	~~Oct 2022~~January 2023

Approving Body/Committee:	Board of Directors
Chair:	David Moss
Signed:	
Date Approved:	~~November 2021~~
Target Audience:	Non-Executive and Executive Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
Oct 2020	1	Oct 2021	July 2020	Company Secretary	New document
May 2021	1.1	Oct 2021	26 May 2021	Assistant Company Secretary	Removed CEO as member of the committee at section 2.1 Added the CEO's attendance at section 2.4 Added CEO's receipt of papers at section 5.4
Oct 2021	1.2	Oct 2022	November 2021	Company Secretary	Added the Care Group Quality & Risk Groups to the reporting groups in sections 1.4 and 9.1 Added Associate Director of AHP/HCS as an attendee in section 2.2 Added that the

					Clinical Lead for Clinical Audit is to attend for the Annual Audit Plan and Annual Report in section 2.2.
Jan 2022	1.3	Jan 2023		Corporate Governance Assistant	Changed “Quality Governance Group” to “Clinical Governance Group” in sections 1.4 and 9.1.

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INDIVIDUAL APPROVAL			
Job Title	Chairman	Date	
Print Name	David Moss	Signature	
COMMITTEE APPROVAL			
If the committee is happy to approve this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of Committee	Board of Directors	Date	
Print Name	David Moss	Signature of Chair	

University Hospitals Dorset NHS FOUNDATION TRUST

Quality Committee

TERMS OF REFERENCE

1. PURPOSE

1.1 The Quality Committee is a committee of the Board of Directors and has no executive powers other than those specifically delegated in these terms of reference.

1.2 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (Children and Vulnerable Adults), Infection Prevention and Control, Medicines Management, Learning from Deaths and End of Life Care.

1.3 The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

1.4 The Quality Committee is responsible for receiving, scrutinising and monitoring the;

i) Quality elements of the Board Assurance Framework and Trust Risk Register;

ii) Quality Reporting Framework;

iii) Assurance of CQC inspection Preparedness Registration & Compliance;

iv) Half yearly and annual reports on Claims;

v) 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;

vi) The learning from Serious Incidents/Patient Safety Incidents in accordance with the national NHS Framework;

vii) The Annual Quality Account Report, Annual Infection Control Report, Annual Patient Survey Report, Annual Complaints 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 and the Annual CQC Self-Assessment Report;

viii) Receive and scrutinise the Annual Radiation Report;

ix) Receive for scrutiny chairmen's reports from the following groups:-

- Medicines Governance Group;
- Nursing and Midwifery Group;
- ~~Quality~~ Clinical Governance Group;
- Mortality Surveillance Group;
- Infection Prevention and Control Group;
- Radiation Protection Group;
- Health and Safety Group;
- Safeguarding Group;
- Care Group Quality & Risk Groups.

in order to provide the Board of Directors with assurance that high standards of care are provided by the Trust and in particular, adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust.

iix) Approve its governance cycle.

2. MEMBERSHIP/ ATTENDANCE

2.1 Membership of the Quality Committee comprises of four Non-Executive Directors, one of whom will be a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer.

2.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Chairman of the Committee and in the event that a report is presented to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Nursing Officers;
- Deputy Chief Medical Officers;
- Director of Infection Prevention and Control;
- Care Group Medical Directors;
- Associate Director of Pharmacy;
- Associate Medical Director (Chair of QGG);
- Care Group Directors of Nursing;
- Associate Director of Quality and Risk
- Clinical Lead for Clinical Audit (Annual Audit Plan and Annual Report);
- IR(ME)R Lead/Chair of Radiation Group (Annual Radiation Report).

- Associate Director of Allied Health Professionals & Healthcare Scientists

2.3 The Committee will be chaired by a Non-Executive Director of the Trust (not the Chairman of the Audit Committee or Finance and Performance Committee). A non-executive Deputy Chairman should be nominated (not the Chairman of the Audit Committee or Finance and Performance Committee). In the absence of the Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

2.4 Only members of the Committee have the right to attend Committee meetings. The Chief Executive Officer will attend on an adhoc basis or as required. Any other directors may attend following notification to the Chairman.

2.5 Any Non-Executive Director not appointed to the Committee may attend with the prior consent of the Chairman.

2.6 There will be one public and one staff governor attending each meeting as an observer. Observers are not members of the Committee. These governor(s) have been nominated to undertake this duty by the Council of Governors.

3. FREQUENCY OF MEETINGS

3.1 The Committee will normally meet on a monthly basis and otherwise as required.

4. QUORUM

4.1 The quorum of the Committee is at least five members, which will include the Chairman (or a Non-Executive Director deputy), and two Chief Officers, one of whom must be the Chief Medical Officer or Chief Nursing Officer.

4.2 If the meeting is not quorate the meeting can progress if those present determine. However no business shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

5. NOTICE OF MEETINGS

5.1 The Committee shall be supported by the Company Secretary.

5.2 Meetings of the Committee shall be called by the Company Secretary at the request of the Committee Chairman.

5.3 The Committee Chairman will agree the agenda and papers to be circulated with the Company Secretary or their nominee.

5.4 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, and supporting papers, shall be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting. A copy of papers for each meeting must be sent to the Chief Executive Officer.

6. ACCOUNTABILITY

6.1 The Committee is accountable through the Board of Directors for monitoring the

Trust's strategic objective 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.

7. RESPONSIBILITIES

7.1 The responsibilities of the Committee are set out in its Constitution (see 1.1) above and in its Governance Cycle.

8. AUTHORITY

8.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

8.2 The Committee is authorised to approve its governance cycle.

8.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

8.4 The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8.5 The Committee is authorised to approve policies in accordance with the Document Control Policy.

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The committee will receive and scrutinise chairmen's reports from the following groups as described in para 1.4 viii:

- Medicines Governance Group;
- Nursing and Midwifery Group;
- ~~Quality~~Clinical Governance Group;
- Mortality Surveillance Group;
- Infection Prevention and Control Group
- Radiation Protection Group;
- Health and Safety Group;
- Safeguarding Group.
- Care Group Quality & Risk Groups

10. REPORTING MECHANISMS

10.1 The Chairman of the Committee will draw to the attention of the Board any issues that require disclosure or further action.

10.2 The Agenda and Papers are available on request to all members of the Board of Directors.

10.3 A formal minute of the meeting will be recorded and these minutes will be available on request to the Board of Directors.

10.4 Action items will be recorded at each meeting and a log kept, monitoring and reviewing progress. A review of the action log will be a standing item on each

agenda.

10.5 The Committee will provide an annual report on its work and how it discharges its responsibilities to the Board of Directors.

10.6 The Committee shall compile a report on its activities to be included in the Trust's Annual Report and Annual Governance Statement.

11. PROCESS

11.1 Quality Assurance

- Ensure that the Trust has effective systems and processes in place for ensuring high standards for quality of care;
- Ensure the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience;
- Provide assurance to the Board of Directors that the Care Quality Commission's fundamental standards for quality and safety are monitored and highlight any gaps in compliance, controls or assurance;
- Review, make comment and gain assurance to the Board on the care and safety issues which are subject to other regulatory scrutiny (e.g. NHS Improvement, NICE);
- Scrutinise, make comment and gain assurance , as decided necessary by the Committee, to the Board on the monthly, quarterly half yearly and annual reporting as set out in Section 1.2;
- Review the Board Assurance Framework ensuring that significant clinical and non-clinical risks are appropriately reflected and any identified gaps in assurance are reported to the Audit Committee and the Board of Directors;
- Review the Quality Scorecard and ensure any significant concerns are escalated to the Board of Directors;
- To be kept fully appraised of all new and current risks rated 12-25, clinical and non-clinical, identified on the Risk Register across the organisation and progress of action plans identified to mitigate these risks;
- Ensure the Board of Directors is kept fully informed of specific clinical and non-clinical matters on the Risk Register where advice on controls has been sought and implemented, illustrating risk mitigation over time;
- Ensure that the Trust regularly reviews and updates, as appropriate, corporate policies relating to the business of the Committee;
- To draw attention to the Board any concerns on care, quality and safety that the Committee may have.

11.2 Patient Experience

- Identify key themes from complaints, PALS and patient engagement, good practice and learning and provide oversight on behalf of the Board of Directors;
- Identify key themes from patient experience quality indicators and provide oversight of action plans to attain assurance;
- Receive by exception, reports relating to patient experience following review at relevant groups.

11.3 Patient Safety

- Review reports on serious incidents, Never Events, claims and inquests to receive assurance that appropriate thematic review, investigation and learning to prevent reoccurrence has been undertaken;

- Ensure a proactive response has been taken to issues identified through internal and external audit and/or inspection reports relating to patient safety, patient experience, quality and risk standards;
- Review mortality, medical examiner and learning from deaths reports and receive assurance on actions required.

11.4 External Reporting

- Oversee, agree and recommend to the Board of Directors the Trust's Annual Quality Account, including the external assurance process;
- Receive and monitor the CQC in-patient survey reports and associated action plans;
- Receive and submit to the Board of Directors any external peer reviews or reports relating to patient experience, clinical effectiveness or patient safety;
- Receive and review clinical performance reports prior to submission to NHS Improvement;
- Receive and monitor the CQC Insight Model Report.

11.5 National Guidance and Policy

- Ensure that all relevant national standards and guidance in relation to quality governance are met to comply with NHS Improvement's requirements;
- Ensure the Trust complies with legislation, national policies and recommendations for safer practice relevant to trust activity by receiving exception reports from the relevant subcommittee where implementation is non-compliant or resource issues have been identified that prevent adequate assurance being achieved in a timely manner.

12. COMMUNICATION

12.1 The minutes of each meeting of the Committee will be formally recorded and submitted to the next meeting of the Committee for approval.

13. MONITORING

13.1 Attendance will be monitored as part of the agenda at each committee meeting. A matrix (see Appendix A) of membership attendees will be used for monitoring purposes.

13.2 The Trust's Annual Report will include membership attendance, frequency of meetings and whether meetings were held in quorum.

14. REVIEW

14.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

14.2 The position of Chairman of the Committee will be reviewed at least every three years.

APPENDIX A

QUALITY COMMITTEE MEETING ATTENDANCE RECORD

NAME OF COMMITTEE:	Quality Committee												
REPORT TO :	Board of Directors												
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**												
Was the meeting held in quorum? (Please refer to Terms of Reference) Y / N													

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS

GOVERNANCE CYCLE 2021

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

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

½ YEARLY & ANNUAL REPORTS	Lead	½ Year	Annual	Part 1/2
Board Assurance Framework • Close/sign off previous year's framework.	CNO	---	May	Part 1
Board Assurance Framework • Annual Framework (Approve)	CNO	---	May	Part 1
Board Assurance Framework • ½ Year Review (Scrutinise) (Subject to Audit Committee scrutiny of process - Nov)	CNO	Nov	---	Part 1
Risk Register Report	CNO	November	May (AR)	Part 2
Annual Infection Prevention and Control Report – Board Assurance Statement	CNO	-----	July	Part 1
Nursing Establishment Review (summary)	CNO	March	September	Part 1
Freedom to Speak Up Guardian Report	CPO	~~January~~May	~~May~~September	Part 1
Guardian of Safe Hours Report	CMO		July	Part 1
Annual Complaints Report	CNO	---	July	Part 1
Annual Safeguarding Report and Statement of Commitment	CNO	----	September	Part 1
National Inpatient and Outpatient Surveys Results	CNO	---	When published	Part 1
Quality Improvement Programme	CSO		March	Part 1
Annual CQC Report	CNO	----	July	Part 1
Quality Assurance for Responsible Officers and Revalidation	CMO	----	July	Part 1

7 Day Services Board Assurance Framework	CMO	May	November	Part 1
Annual Health and Safety Report	CNO		July	Part 1
Annual Staff Survey Report and Action Plan	CPO	-----	When published	Part 1
Workforce Race Equality Standards Action Plan	CPO	----	September	Part 1
Local Clinical Excellence Awards	CPO		November	Part 1
Annual SIRO Report	CIO	---	May	Part 1
Annual Estates Report	CSTO		May	Part 1
Annual Winter Plan	COO		November	Part 1
EPRR Assurance	COO		September	Part 1
Annual Security Report	COO	---	May	Part 1

CORPORATE GOVERNANCE REPORTS	**Lead**	**Annual Reports**	**Part 1/2**
Code of Conduct (5 yearly)	CoSec/ Chairman	October 2025	Part 1
Constitution (3 yearly) (Note CoG Approval)	CoSec/ Chairman	October 2023	Part 1
Scheme of Reservation & Delegation (Approve 3 yearly)	CoSec/ CEO	March 2023	Part 1
Standing Financial Instructions	CFO	October	Part 1
Approve Register of Compliance with Licence Conditions	CEO/CoSec	March	Part 1
Approve Register of Compliance with Code of Governance	CEO/CoSec	March	Part 1
Annual review of the effectiveness of third party processes and relationships (Code of Governance: Comply or Explain)	CEO/HoC	March	Part 1
Audit Committee Terms of Reference	Chair (AC)/CoSec	November	Part 1
Finance & Performance Committee Terms of Reference	Chair F&P/CoSec	November	Part 1
Quality Committee Terms of Reference	Chair QC/CoSec	November	Part 1
Workforce Strategy Committee Terms of Reference	Chair WSC/CoSec	November	Part 1
Workforce Strategy Committee Annual Report	CoSec	July	Part 1
Quality Committee Annual Report	CoSec	July	Part1
Finance and Performance Committee Annual Report	CoSec	July	Part 1
Transformation Committee Annual Report	CoSec	July	Part 1
Sustainability Committee Annual Report	CoSec	July	Part 1
Audit Committee Annual Report	CoSec	July	Part 1
Private Patient Strategy Committee	CoSec	July	Part 1
Charitable Funds Committee Annual Report	CoSec	July	Part 1
Seal of Documents Register	CoSec	May	Part 1
Gifts & Hospitality Register	CoSec	May	Part 1

Register of Interests	CoSec	May	Part 1
Board Reporting Governance Cycle (Approve)	Co Sec	March	Part 1
Annual Board Effectiveness Report	CoSec	March	Part 1
Independence of Non-Executive Directors (Annual Report requirement)	CoSec	March	Part 1
Board Meeting Schedule	CoSec	May	Part 1

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

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

CS – Company Secretary