University Hospitals Dorset NHS Foundation Trust

Council of Governors Meeting

Wednesday 28 January 2021

16:30 – 18:30

Via Microsoft Teams

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

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

The first meeting of the University Hospitals Dorset NHS Foundation Trust Council of Governors will be held at 4.30pm on **Thursday 28 January 2021** via Microsoft Teams

If you are unable to attend please notify the Company Secretary's Team, telephone 0300 019 8723.

Chairman

AGENDA – PART 1

4.30pm	1	Welcome and Apologies for Absence:		
	2	Declaration of Interests		
	3	Patient Story		
	6	Chairman's Comments		Chairman
	7	Capital Programme for University Hospitals Dorset (*presentation)*		CSO S Killen
	8	University Hospitals Status and ambitions		CSO S Tee
	9	**QUALITY & PERFORMANCE**		
	9.1	For information	Integrated, Quality, Performance, Workforce and Finance Report	Chief Officers
	9.2	For information	Update on Covid	CNO
	10	**STRATEGY AND TRANSFORMATION**		
	10.1	For information	Update on Transformation (to include Estates)	CSO
	11	**GOVERNANCE**		
	11.1	For approval	Terms of Reference: Nominations, Remuneration and Evaluation Committee	Chairman CoSec
	11.2	For approval	Proposed Process for the Appointment of the Lead Governor	Chairman CoSec
	11.3	For information	Board Policy for Engagement with the Council of Governors	Chairman CoSec

6pm	12	Motions on Notice	Chairman
	13	Urgent Motions or Questions	Chairman
	14	Any Other Business	Chairman
	15	**Date of next meeting: Thursday 29 April 2021 at 4.30pm via Microsoft Teams**	
	16	*Note: A glossary of abbreviations that may be used in these papers will be found at the back of this document*	

* Late paper

6.15pm	17	**AGENDA – PART 2**	
	18	Chairman's Comments	Chairman
6.20pm	19	**STRATEGY and TRANSFORMATION**	
	19.1	To receive 2021/22 Update on the Annual Operational Plan *(verbal)*	CFO
	19.2	To receive ICS Development	CEO
	20	Any Other Business	
	21	Reflection on Current Meeting	
	22	**Date of next part 2 meeting: Thursday 29 April 2021 at approximately 6pm in the Board Rooms, Poole Hospital NHS Foundation Trust**	
pm	23	**Close of Meeting**	

* Late paper

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 January 2021

Agenda item: 9.1

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

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

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

Key points for Council of Governors members:

Areas of Board Focus

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

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

Operational Performance

Emergency Care

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

Operational (Field testing standards) and Internal Care Standards

(colours based on change from last month)

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

The other key emergency care related standards/metrics are:

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

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

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

Key points for Council of Governors members:

Surge and Escalation Planning

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

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

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

Referral to Treatment (RTT)

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

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

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

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

Key points for Council of Governors members:

Factors impacting on standard.

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

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

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

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

Key points for Council of Governors members:

DM01 (Diagnostics report)

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

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

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

High level actions include:

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

Cancer Standards

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

Performance

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

Key points for Council of Governors members:

Factors impacting on standard.

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

High Level Actions ongoing

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

Quality, Safety, & Patient Experience

Infection Control

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

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

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

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

Key points for Council of Governors members:

Workforce

12 month rolling rates to December 2020:

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

Performance

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

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

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

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

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

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

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

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

Factors impacting on standard.

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

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

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

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

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

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




December 2020

Created January 2020

Performance at a Glance - Key Performance Indicator Matrix

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

RESPONSIVE

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

Quality - SAFE

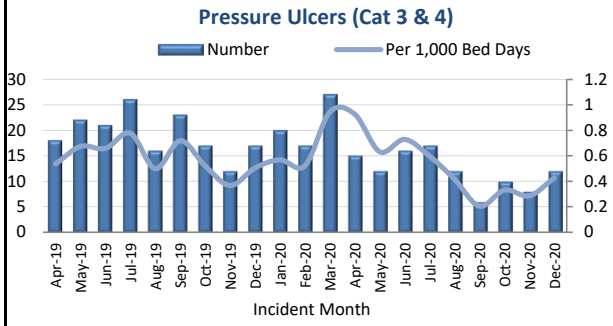
Commentary on high level board position

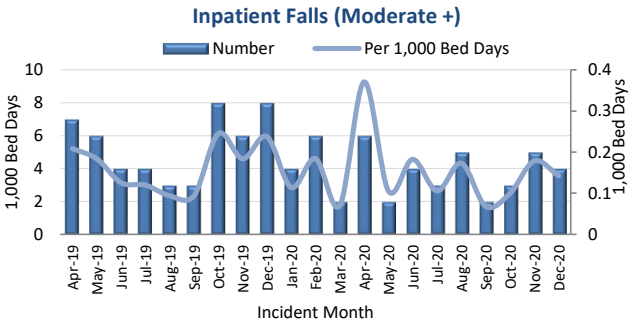
- One (1) new SI reported in month (Dec 2020). YTD figure slightly lower than 2019/20 trajectory.
- Pressure ulcers, work continues on aligning practice and equipment including standardised policies. Nasal cannula with ear protection introduced at RBH site as in Poole.
- Falls, IPC protocols continue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

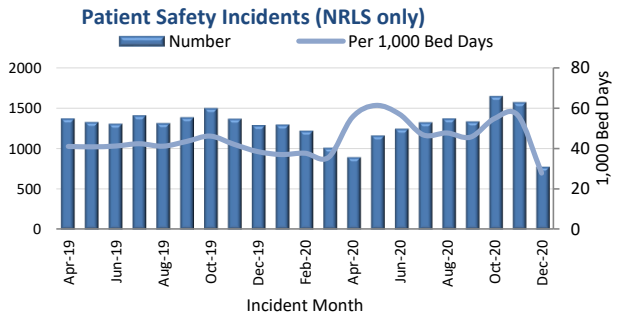
High level Board Performance Indicators

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

High Level Trust Performance





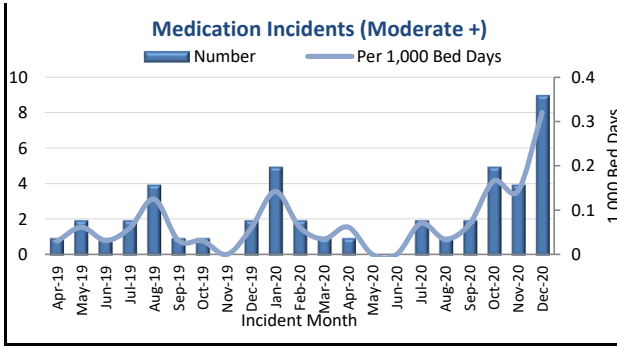


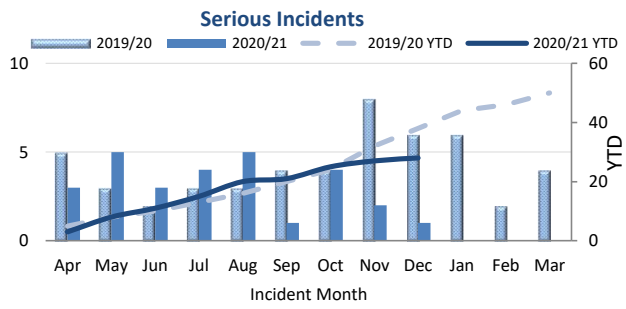
0 (Oct 20) | MRSA | 0 (Nov 20)

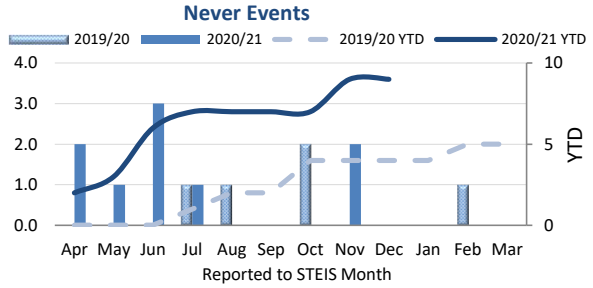
3 (Oct 20) | MSSA | 9 (Nov 20)

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

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







Quality - RESPONSIVE

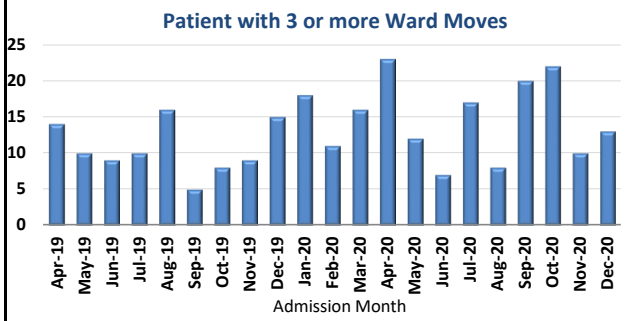
Commentary on high level board position

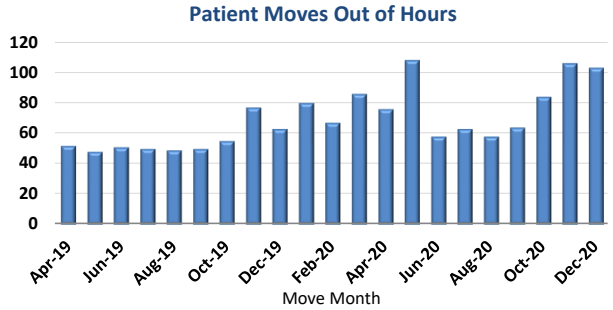
- ENA falls, MUST and Waterlow Assessment compliance has shown some improvement from April - December 2020 but remains an area of focus. Individual ward compliance scores are included in ward Quality dashboards at each site.
- The National Mixed Sex Accomnodation return has been suspended from April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

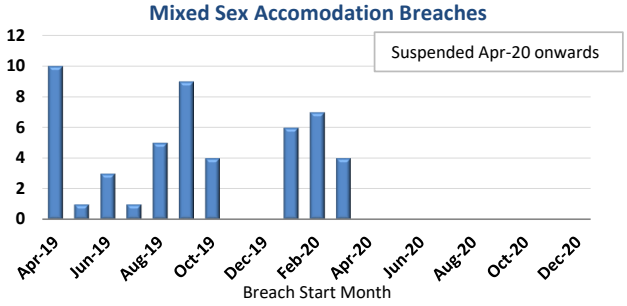
High level Board Performance Indicators

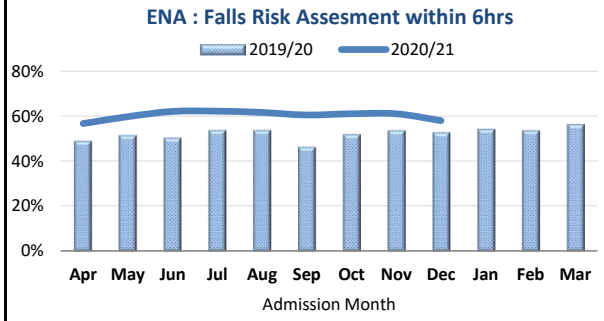
		20/21 YTD	19/20 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)		132	96	-36
Patient Moves Out of Hours (Non-Clinically Justified Only)		720	495	-225
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid		0	33	N/A
ENA Risk Assessment				
**infection eNA assessme went live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

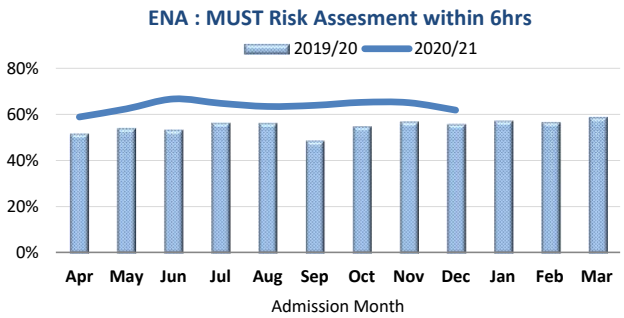
High Level Trust Performance

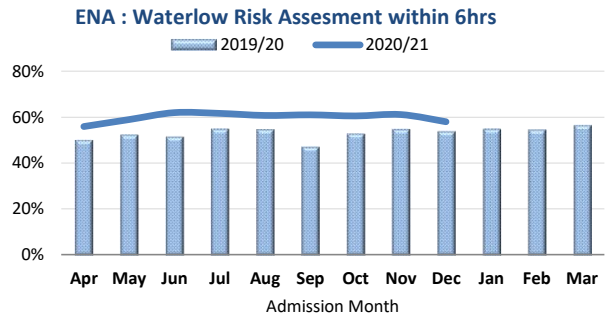












Quality - EFFECTIVE AND MORTALITY

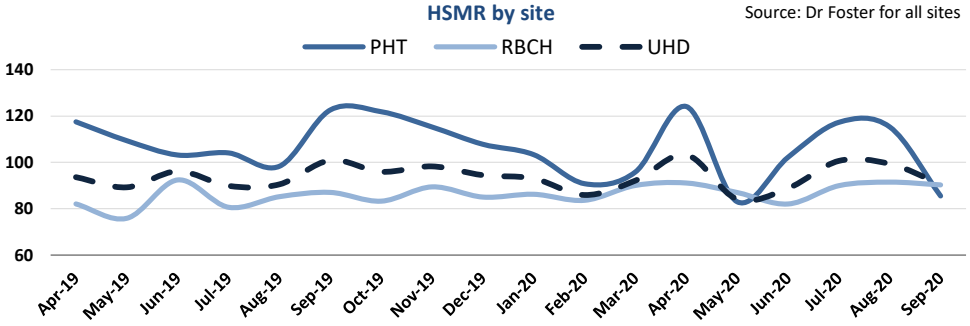
Commentary on high level board position

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

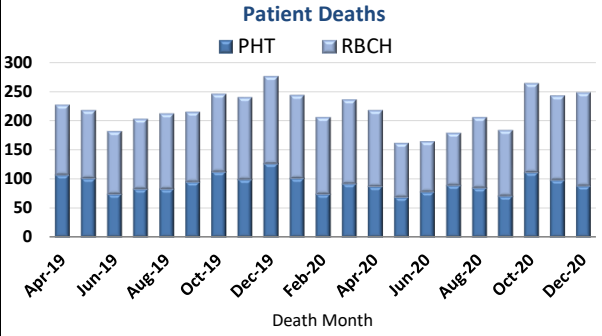
High level Board Performance Indicators

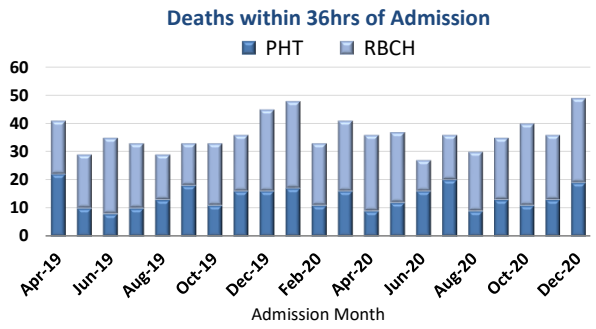
			20/21	19/20	Variance
HSMR (Source: Dr Foster for all sites)	Latest	(Sep 20 - UHD)	90.7	92.2	
Patient Deaths		YTD	1878	2028	**150**
Death Reviews		Number	378	810	**N/A**
Note: 3 month review turnaround target		Percentage	22%	50%	
Deaths within 36hrs of Admission			326	314	**12**
Deaths within readmission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

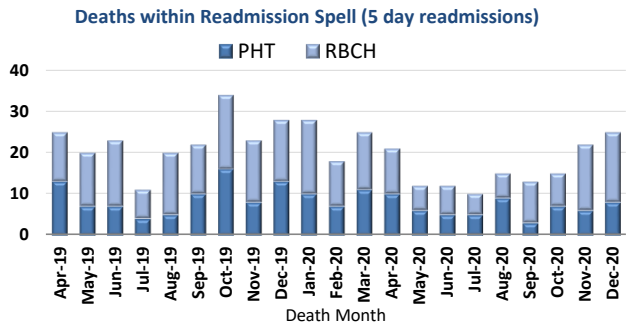
High Level Trust Performance



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







Quality - CARING

Commentary on high level board position

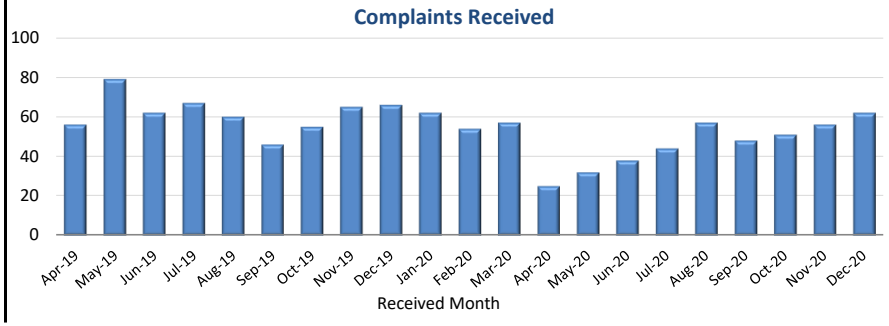
- The new Friends and Family test has been launched with national reporting expected to be published February 2021. Feedback from patients during the last quarter has been fairly consistent, with 91% of our patients reporting their experience as very good/good.
- Section 42's are lower this year due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

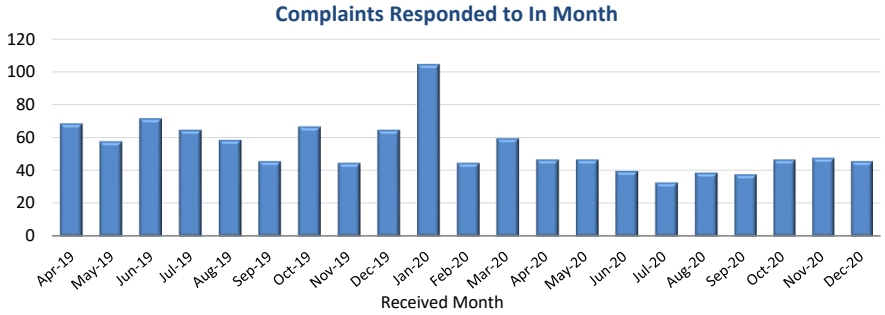
High level Board Performance Indicators

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

Return changed 20/21

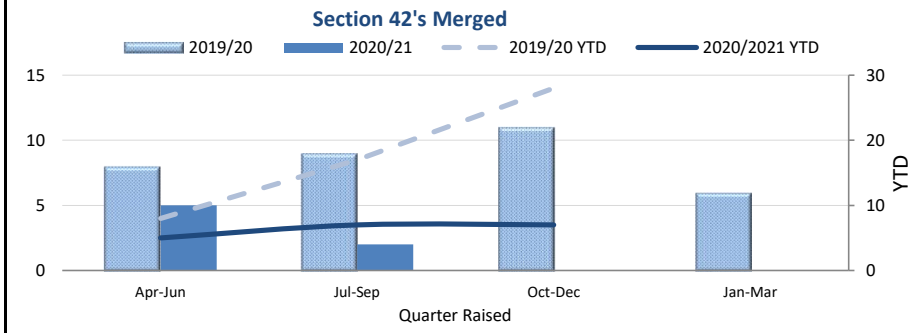
High Level Trust Performance

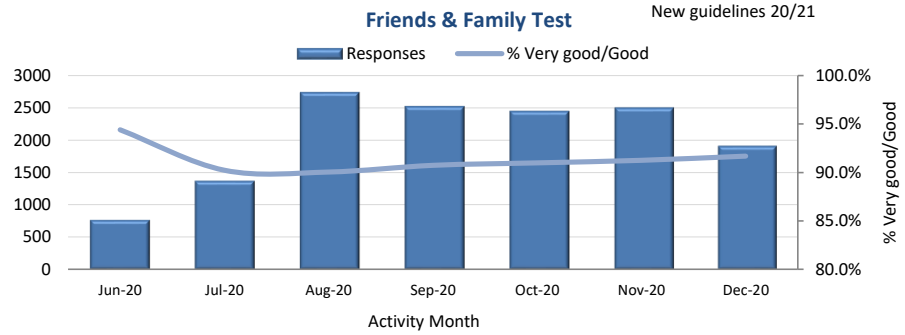




56 (Nov 20) | Complaints Received | 62 (Dec 20)

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





Quality - WELL LED

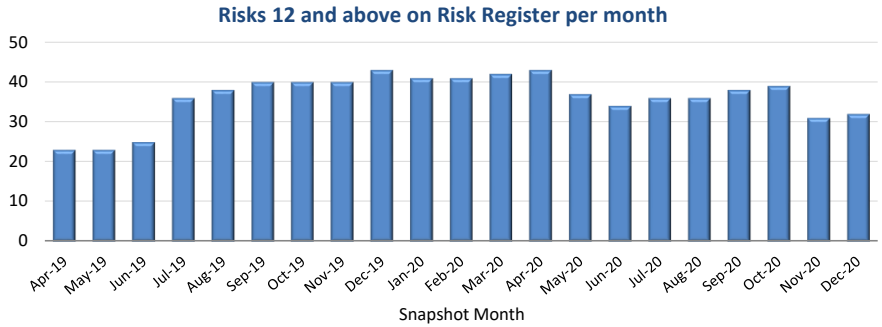
Commentary on high level board position

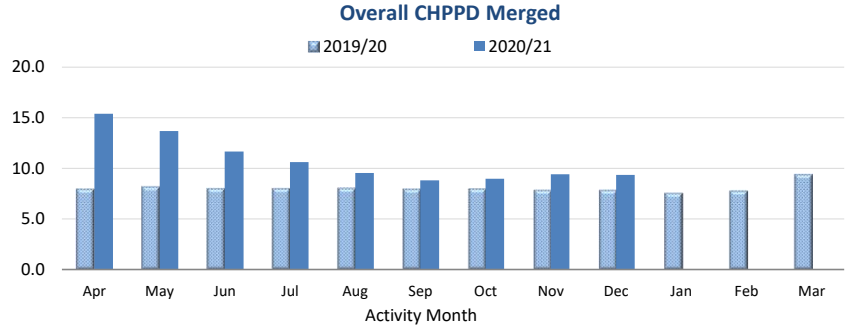
- Work continues to align the Risk registers for the Poole and RBCH sites. Care Group and Corporate Directorate leads are being supported by the Quality and Risk team to review and combine similar site risks into single UHD risks as appropriate. A deciison has been made to move all current risks over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

High level Board Performance Indicators

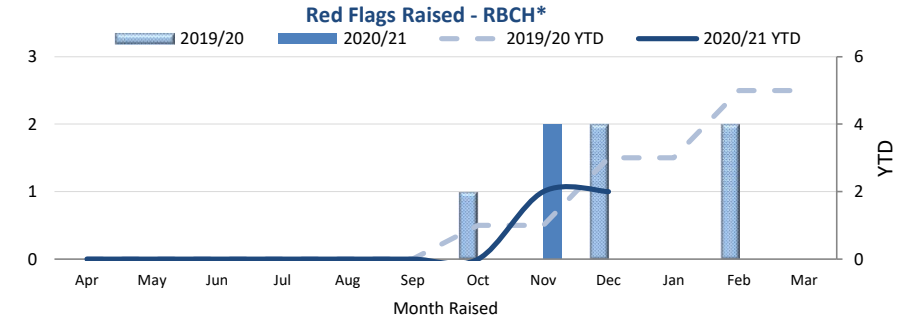
	20/21 YTD	19/20 YTD	Variance
Risks 12 and above on Register	32	43	-11
Red Flags Raised* *different criteria across RBCH & PHT	298	481	-183
Overall CHPPD	10.5	8.0	2.5
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance

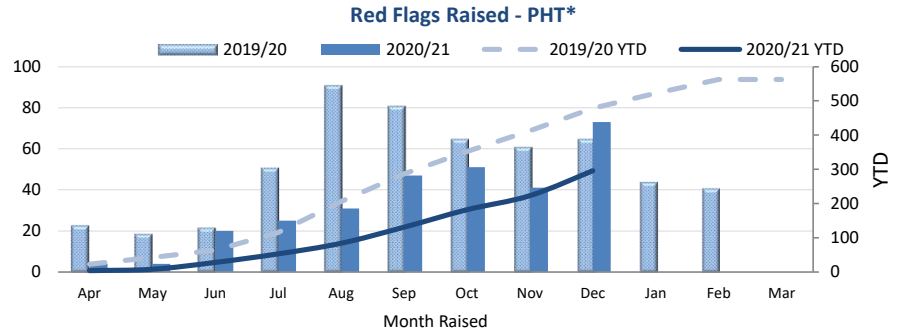




31 (Nov 20) Risks 12+ 32 (Dec 20)



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



Workforce

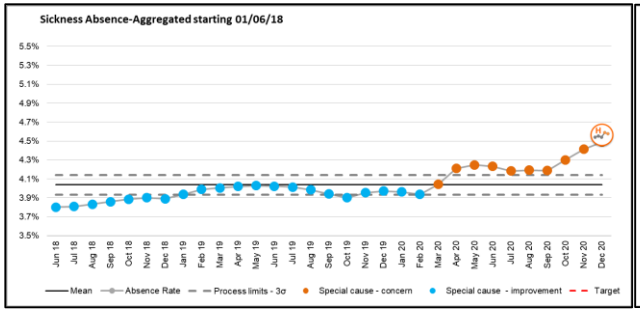
Commentary on high level board position

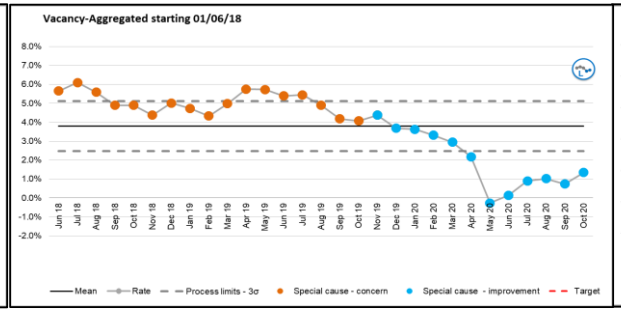
- Overall turnover continues to track lower than usual and vacancy rates are reporting very low due to a year where mobility is restricted and were staff sourcing and recruitment is not typical.
- Overall sickness levels remain steady, however we have seen a marked increase in Covid related absence due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

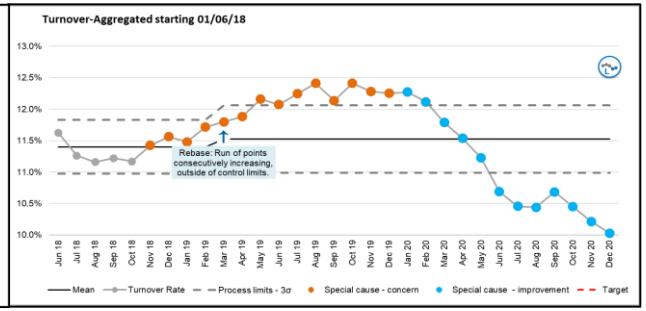
High level Board Performance Indicators

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

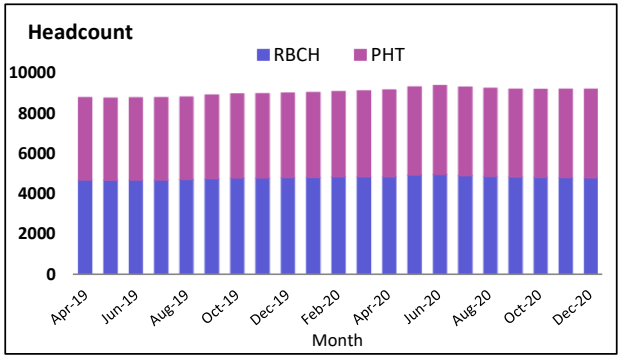
High Level Trust Performance

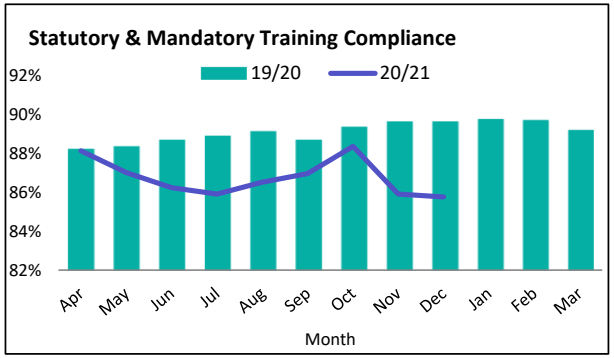


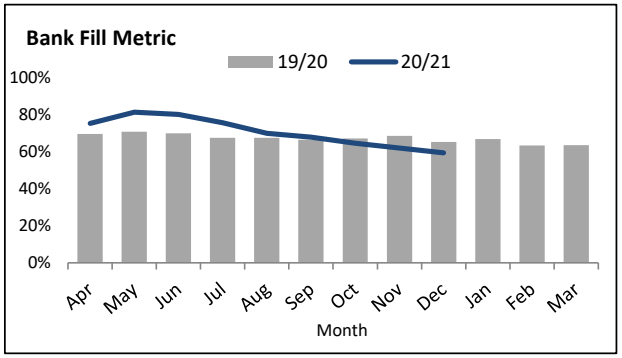




29.9% (Nov 20) | Appraisals (Medical) | 50.3% (Dec 20) | 61.5% (Nov 20) | Appraisals (Values) | 63.9% (Dec 20) | 10.7% (Nov 20) | Turnover | 10.0% (Dec 20) | 4.2% (Nov 20) | Sickness | 4.5% (Dec 20)







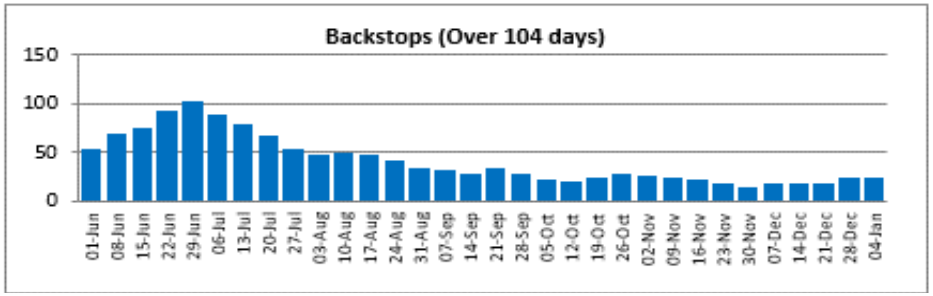
Cancer - Actual November 2020 and Forecast December 2020

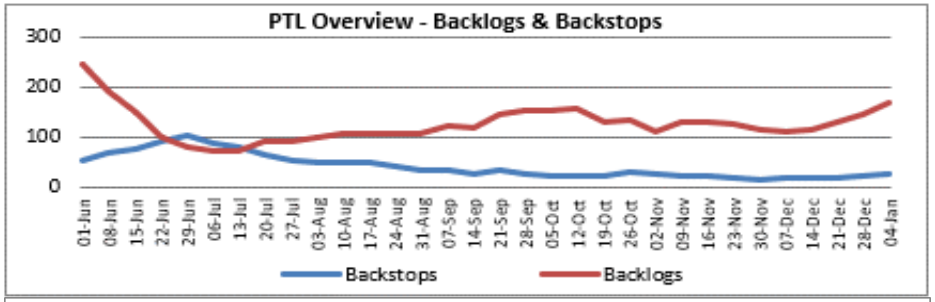
Commentary on high level board position

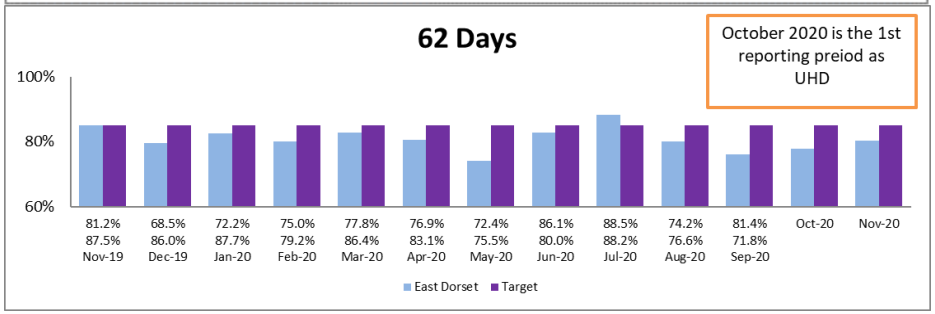
The Trust continues to have challenges managing the volume of 2 week wait referrals- especially in head and neck, (PHT site) Gynae and breast (RBH site) , with several teams having to provide additional capacity to cope. Even with this pressure the Trust has managed to sustain 28 day FDS target.
62 day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

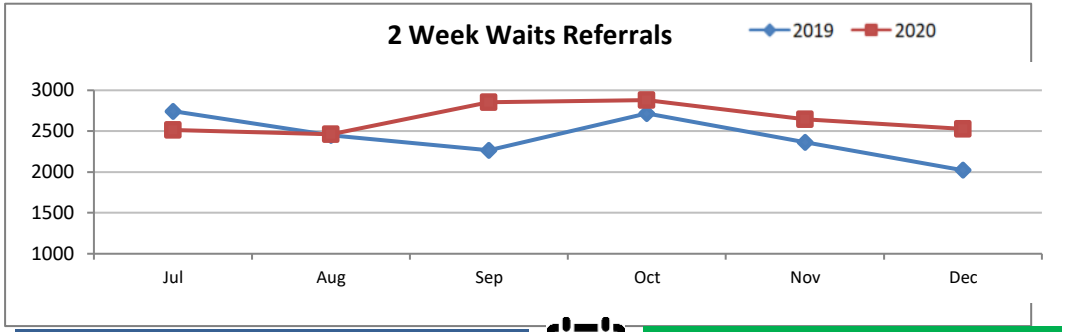
High level Board Performance Indicators & Benchmarking

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

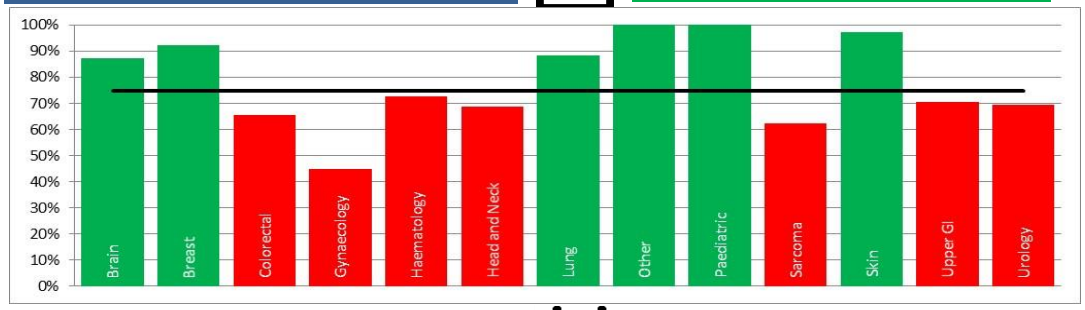




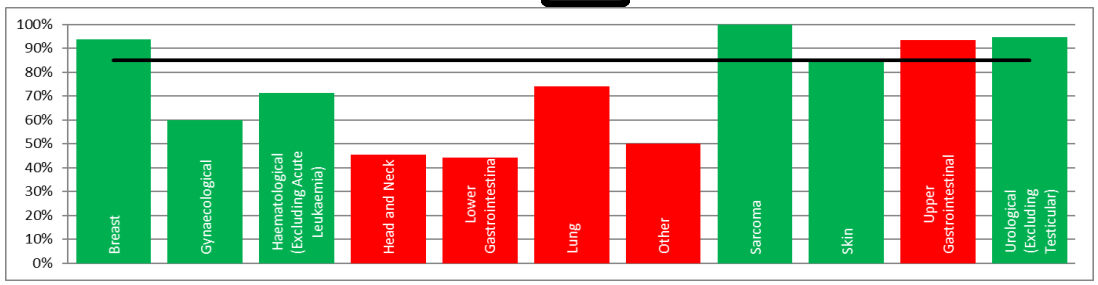




Target 75% | **28** | **UHD: Nov 2020: 86.7%**



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



Emergency

Commentary on high level board position

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

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

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

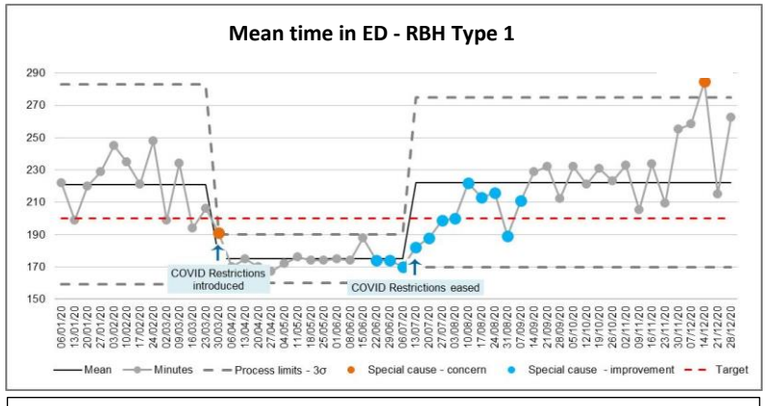
High level Board Performance Indicators

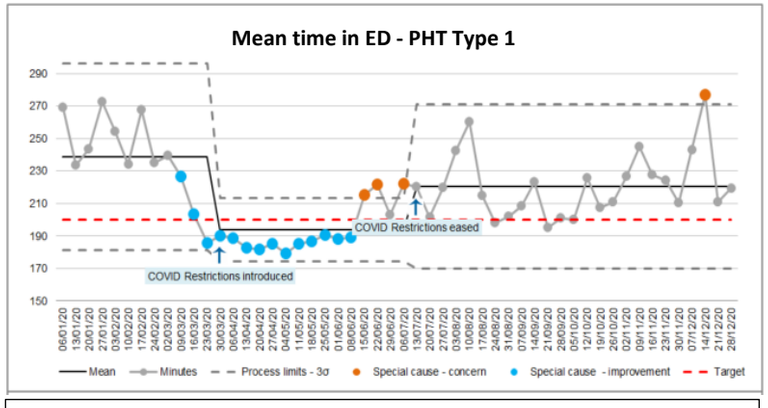
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	6
Clinician seen <60 mins		4385
PHT Mean time in ED	200	235
RBCH Mean Time in ED	200	259
Patients >12hrs from DTA to admission	0	8
Patients >6hrs in dept		2126
ED attendance Growth (YTD)		-21.8%
Ambulance Handover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

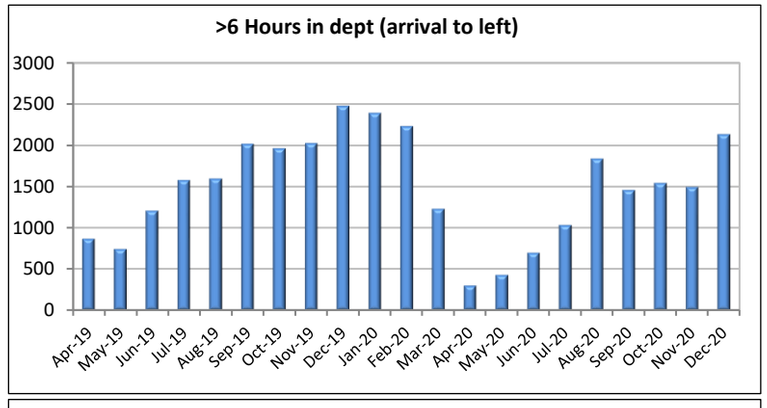
5 mins Nov-20 | Mean time to initial assessment | 6 mins Dec-20

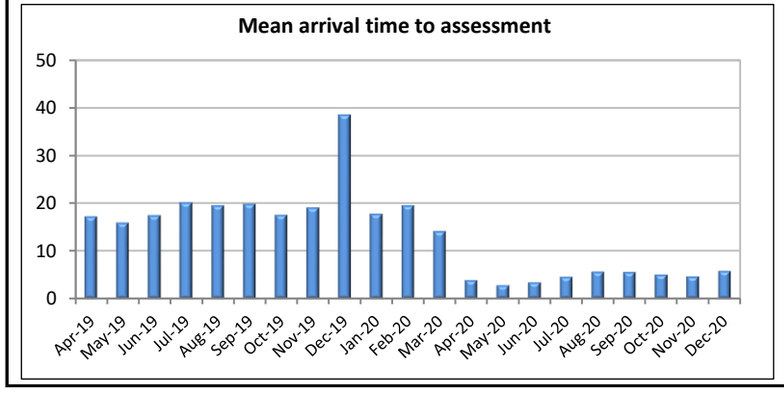
248 mins Nov-20 | Mean time in Dept RBH & PHT | 224 mins Dec-20

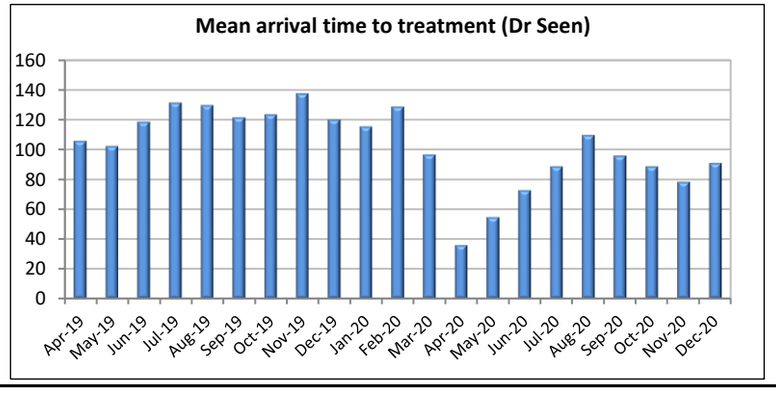
High Level Trust Performance

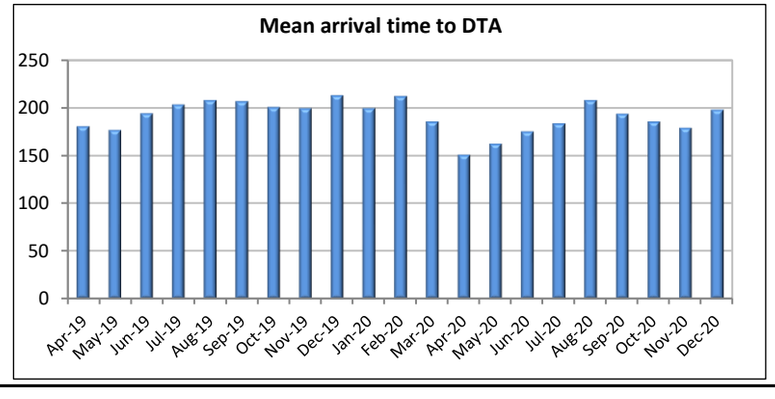












Elective & Theatres

Commentary on high level board position

18 Weeks Referral to Treatment

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

Theatre utilisation

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

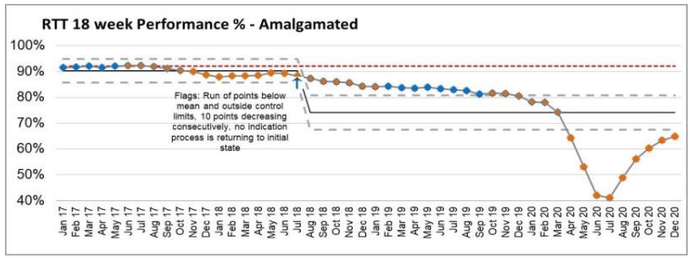
Trauma

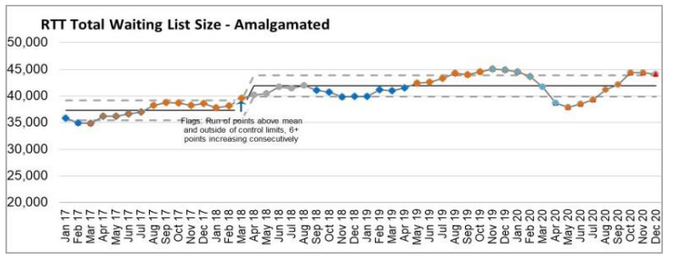
- Hip fractures within 36 hours of being clinically fit for surgery (CCG 95% standard) is currently 56.4% (74%.last month)

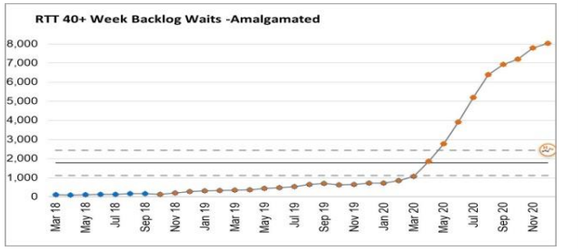
High level Board Performance Indicators & Benchmarking

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

High Level Trust Performance

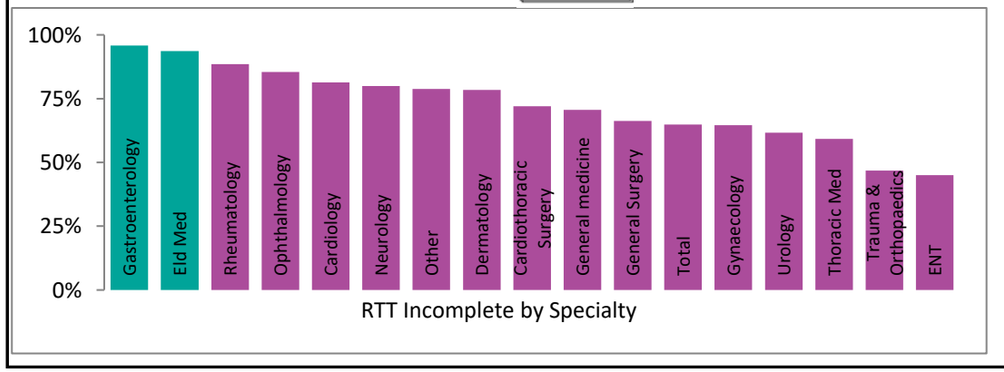


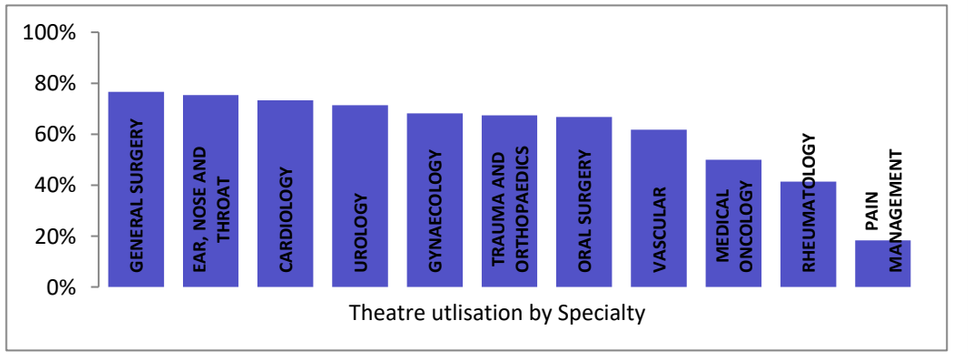




RTT Incomplete 64.8% <18weeks 18 WEEKS (Last month 63%) Target 92%

Theatre Utilisation 72% (Last month 69%)





Referral to Treatment (RTT)

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

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

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

December 2020

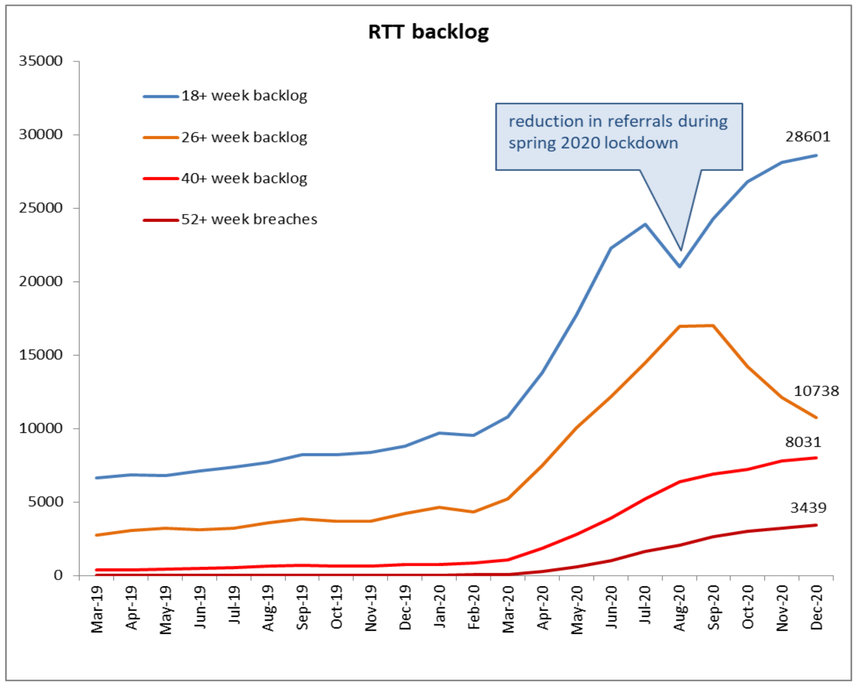
28,601 increase > 18 weeks
10,738 decrease > 26 weeks
8,031 increase > 40 weeks
3,439 increase > 52weeks

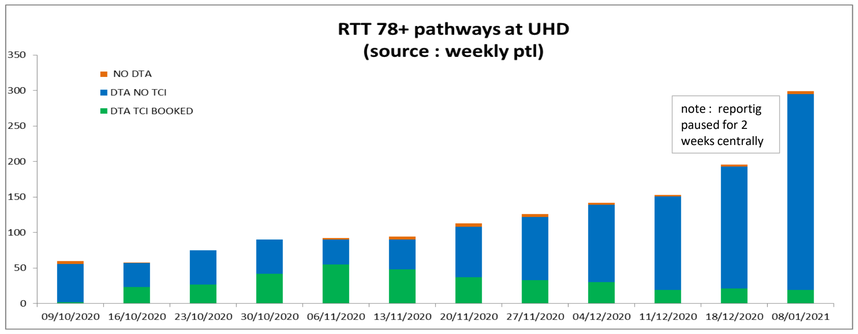
From October all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks, this was paused for 2 weeks centrally over Christmas/New Year.

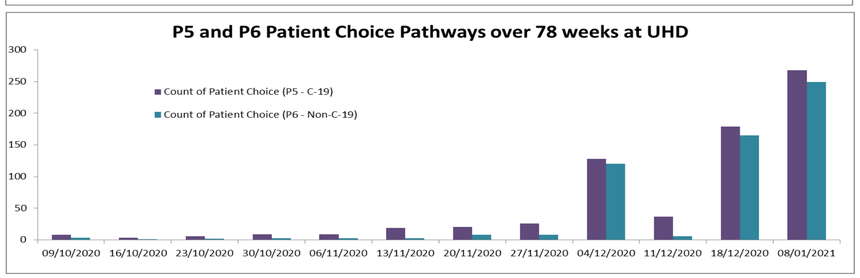
During the first wave of the Covid-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in elective activity including out patient appointments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

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

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







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

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

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

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

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

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

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

Escalation Report

Dec-20

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

Activity | Response

Definition of Trauma Quality Targets & Compliance Achieved

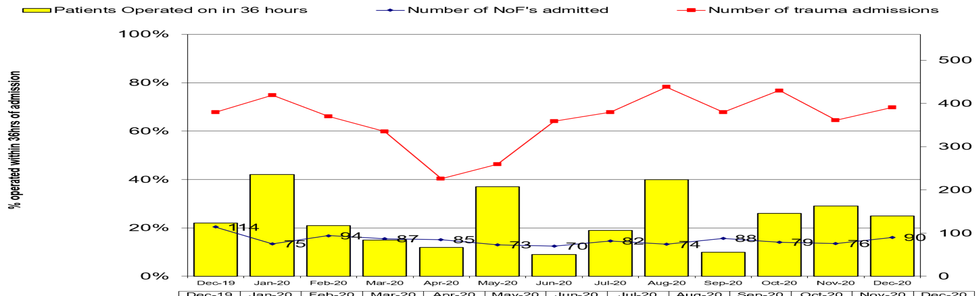
NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
December 2020 Compliance: 25%

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

Breakdown of Breach Reasons and Waiting Times

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

Demand on Trauma Directorate during December 2020



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

Escalation Activity in December

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

Mitigations and Reset

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

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

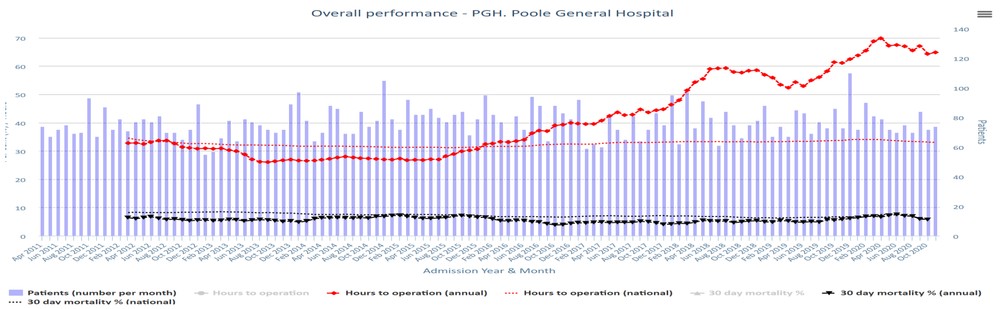
Complexity of Case Load

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

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

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

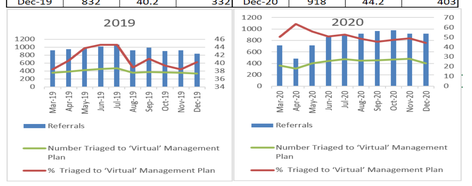
Neck of Femur QSPC Focus



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

December Update on virtual fracture clinic

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



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

Author John West

Patient Flow

Commentary on high level board position

Patient Flow

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

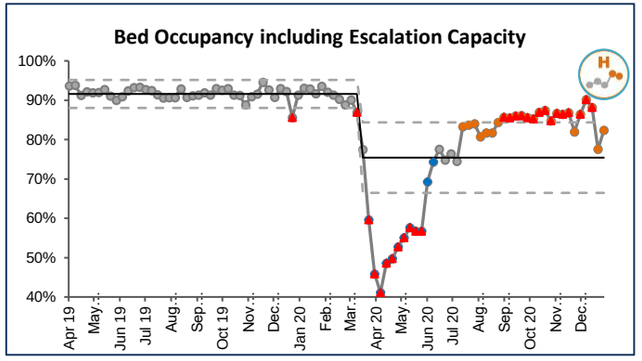
The number of beds consumed by patients with a length of stay greater than 7 days in December was a similar level to those observed in November. An average of 379 beds a day were consumed in December compared to 385 in November (and compared to 450 in December 2019). Bed consumption by patients with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

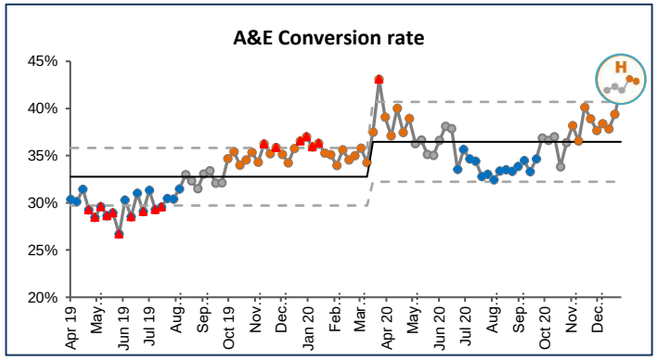
The stabilsied discharge to admission ratio and length of stay metrics is reflected in a favourable occupancy rate of 85.2% in December (85.4% in November), and this remains below the 90.5% observed in December last year. However, lost beds due to infection control protocols, together with acuity (also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

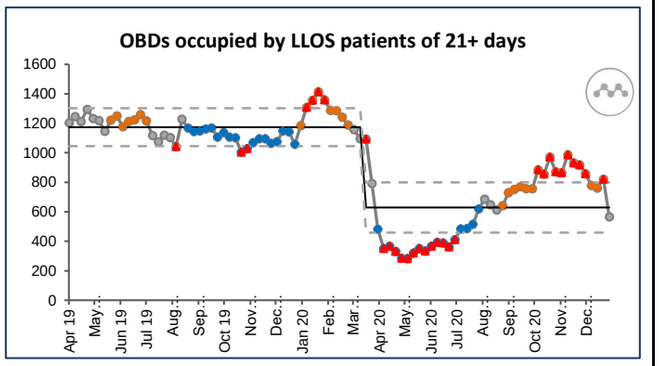
High level Board Performance Indicators & Benchmarking

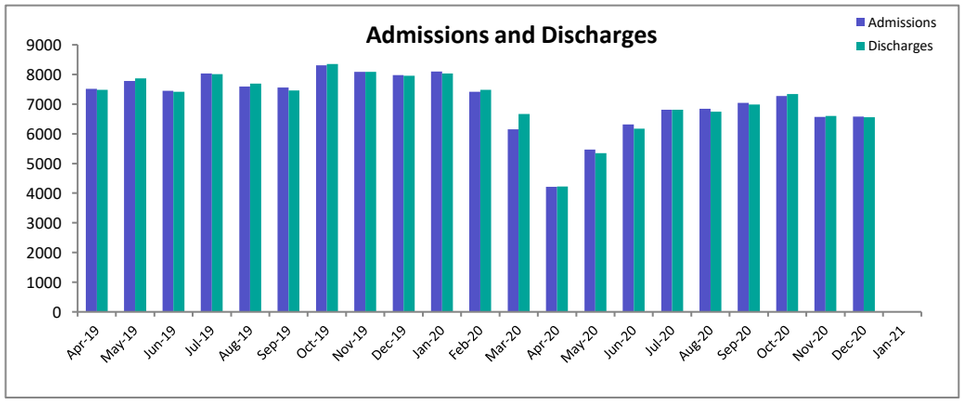
December 2020	Standard		Merged Trust
Patient Flow			
Bed Occupancy	85%		85.2%
Stranded patients:			
Length of stay 7 days		*42%*	379
Length of stay 14 days		*21%*	206
Length of stay 21 days	108	*12%*	118
Non-elective admissions			5,822
> 1 day non-elective admissions			3,685
Same Day Emergency Care (SDEC)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

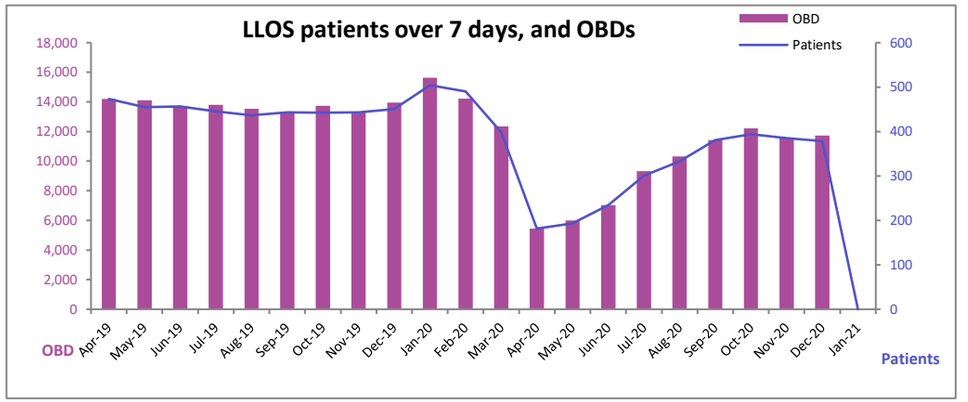
High Level Trust Performance (weekly)











Exception Report

October 20

OCCUPANCY

What is driving occupancy?

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

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

Challenges

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

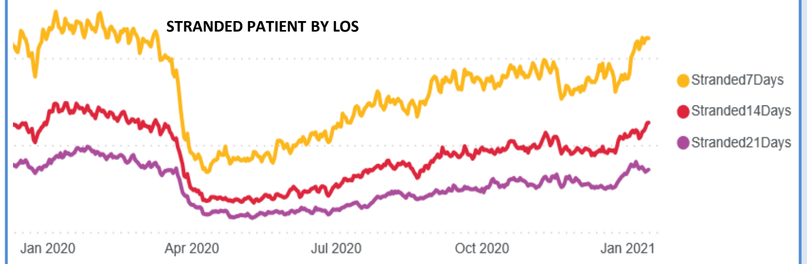
Governance

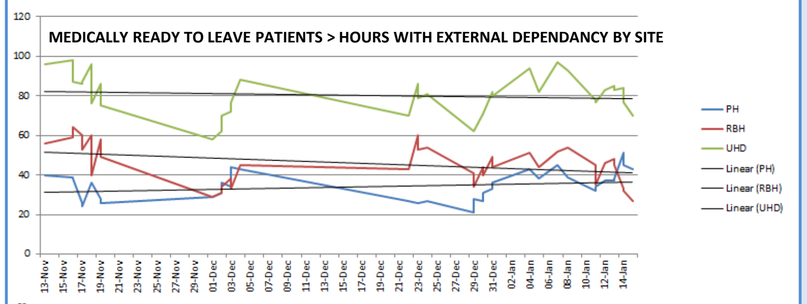
- Home First Board with Executive sponsorship and leadership continues to oversee the implementation of the D2A model.
- Bronze system command in place reporting to Silver system command structure overseeing systemwide action plan to reduce occupancy across bed base.

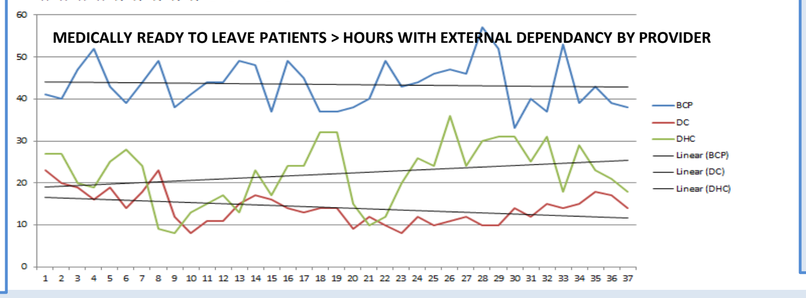
Delivery

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

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







Improvement Actions - winter

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

D2A 'Home First' Model

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

System Support

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

Lead Director Mark Mould

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

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

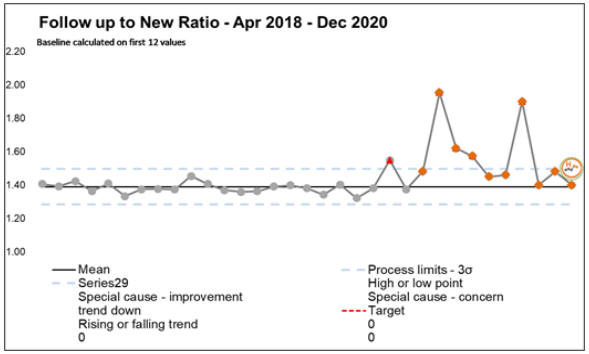
Diagnostics

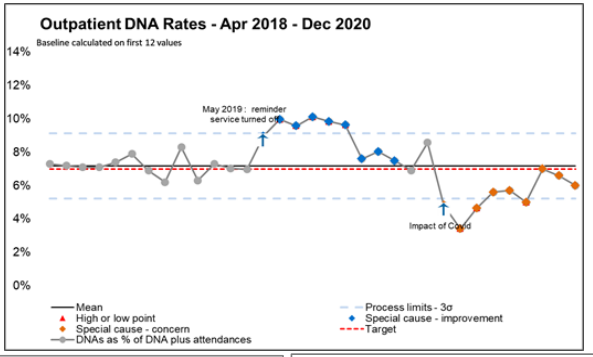
- 97.3% of all diagnostics tests were achieved within the required 6 weeks, of which Radiology achieved 99.5%
- Endoscopy and imaging capacity constrained by Infection Control requirements . Endoscopy 91.3% within 6 weeks, with all elements achieving 90%+ with the exception of Cystoscopy which is slightly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

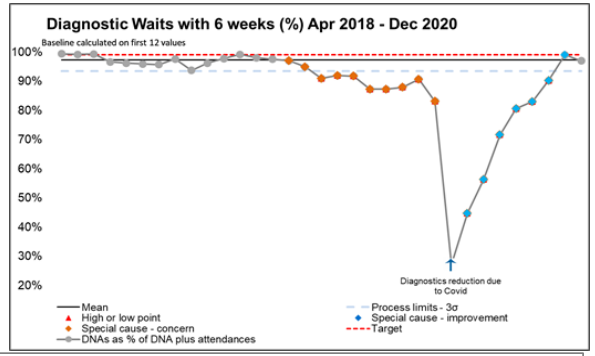
High level Board Performance Indicators & Benchmarking

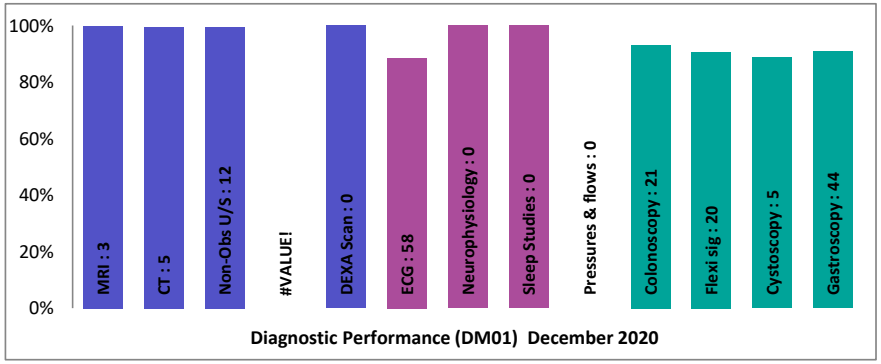
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 19/20 v 20/21)*	-0.5%	96925 / 69551	-28.2%
Total Referrals Rate year on year +/-		-0.5%	168153 / 126951	-24.5%
Outpatient metrics				
Follow up backlog				13,941
Follow-Up Ratio		1.91		1.44
% DNA Rate	*(New & Flup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

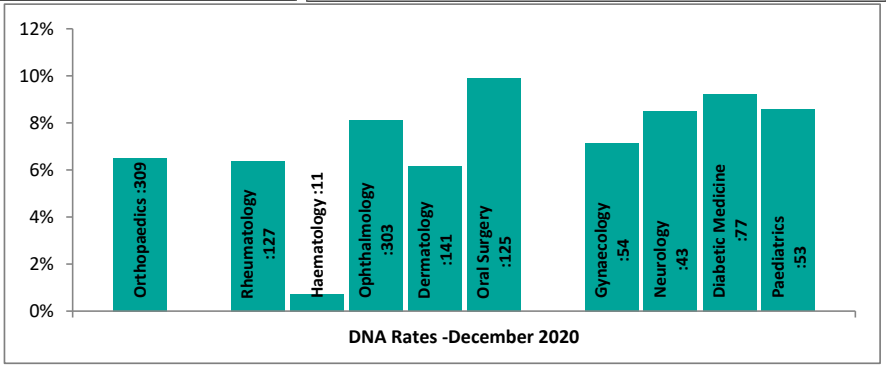
High Level Trust Performance











FINANCE

Commentary

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

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

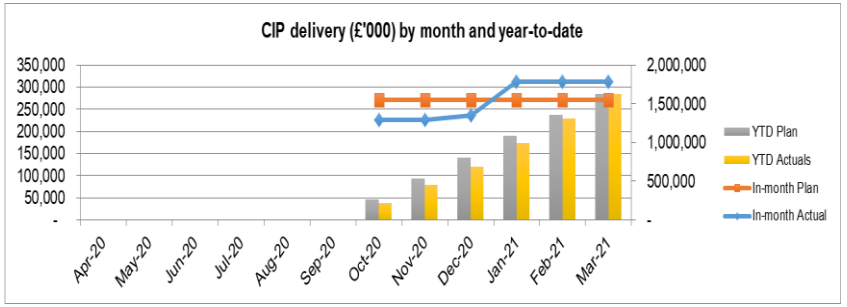
This challenging position makes it very difficult to forecast the financial outturn of the Trust with any certainty. As such, an indicative forecast has been prepared based on a suite of assumptions which are reasonable, but likely to change as the pandemic evolves. This indicative forecast suggests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

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

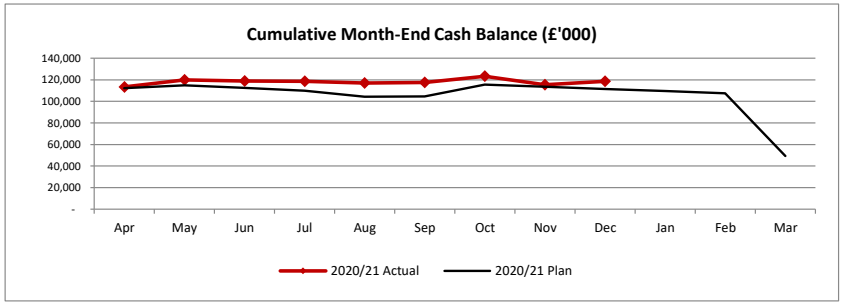
Recurrent cost savings of £687,000 have been achieved to date being £124,000 below target. Plans are now in place to recover this shortfall recurrently over the next three months.

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

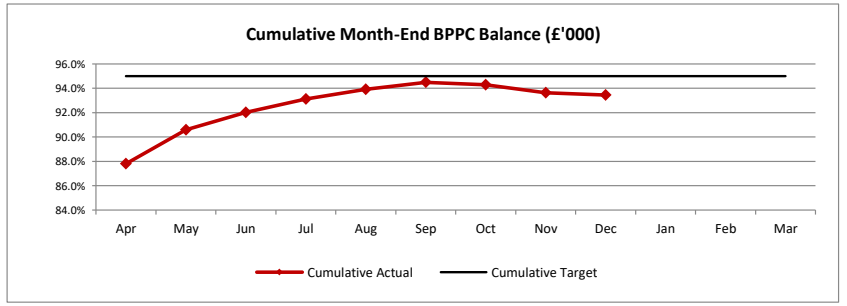
FINANCIAL INDICATORS	Year to date			Forecast
	Budget £'000	Actual £'000	Variance £'000	Variance £'000
Control Total Surplus/ (Deficit)	(2,645)	(1,678)	967	1,498
Capital Programme	34,468	24,346	10,122	13,740
Closing Cash Balance	111,451	118,662	7,211	0
Public Sector Payment Policy	95%	93%	-2%	0



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



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



University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 January 2021

Agenda item: 11.1

Subject:	The Nominations, Remuneration and Evaluation Committee Terms of Reference

Prepared by:	Carrie Stone, Company Secretary and David Moss, Chairman
Presented by:	David Moss, Chairman and Carrie Stone, Company Secretary

Purpose of paper:	To review the Terms of Reference of the Nominations, Remuneration and Evaluation Committee Terms of Reference for the Council of Governors of University Hospitals Dorset NHS Foundation Trust.
Background:	The Terms of Reference were drafted following a review against UHDFT's Constitution and Monitor's Code of Governance (July 2014).
Key points for Council of Governors members:	The key points are: • The Terms of Reference will be reviewed on an annual basis. • The Committee is a sub-committee of the Council of Governors; • The Committee is responsible for advising and/or making recommendations to the Council of Governors relating to: • The evaluation of the performance of the Chairman and Non-Executive Directors; • The remuneration, allowances and other terms and conditions of office for the Chairman and Non-Executive Directors; • The recruitment process for the selection of candidates for the office for the Chairman and Non-Executive Directors; • the composition of the Council of Governors and the skill-mix of the Non-Executive Directors; • Consideration of the continuing absence of Council Governors • The Terms of Reference include details pertaining to membership, frequency of meetings, quorum, authority, reporting mechanisms, process and review.
Options and decisions required:	To approve the Terms of Reference or make further amendments.
Recommendations:	To approve the attached Terms of Reference.
Next steps:	To add to the Trust's website.

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

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

NOMINATIONS, REMUNERATION AND EVALUATIONS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Nominations, Remuneration and Evaluations Committee is a sub-committee of the Council of Governors.

1.2 The Committee is responsible for advising and/or making recommendations to the Council of Governors relating to:

i) The evaluation of the performance of the Chairman and Non-Executive Directors;

ii) The remuneration, allowances and other terms and conditions of office for the Chairman and Non-Executive Directors;

iii) The composition of the Council of Governors and the skill mix of the Non-Executive Directors;

iv) The recruitment process for the selection of candidates for the office of Chairman or other Non-Executive Directors;

v) The consideration of the continuing tenure of absentee Governors.

1.3 The Nominations, Remuneration and Evaluations Committee will produce an Annual Report on its own work.

2. MEMBERSHIP

2.1 The Chairman of the Trust, or in his absence, the Vice Chairman is to preside at meetings of the Nominations, Remuneration and Evaluation Committee. If the Chairman is absent from a meeting or temporarily absent on grounds of a declared interest the Vice-Chairman shall preside. If the Chairman and Vice-Chairman are absent, such Non-Executive Director as the Governors present shall choose shall preside. The Committee will comprise of three public governors, one appointed governor and one staff governor.

2.2 Governors comprising the Committee will be nominated by constituency. Where there is more than one nomination a ballot of that constituency will take place. The term of office will be for a 3 year term with a permitted maximum of 2 x 3 year terms.

2.3 In discharging its responsibilities the Chief Executive of the Trust will be entitled to attend the meeting of the Committee unless the Committee decides otherwise, and the Committee will be required to take account of the Chief Executive's views.

2.4 For the appointment of Chairman to the Trust the Committee will seek the services of an Independent Assessor.

2.5 For all appointments and matters relating to remuneration the Committee will seek advice from the professional human resources services of the Trust who may in turn look for professional external support.

3. FREQUENCY

3.1 The Committee will meet four times a year. Additionally if required for Chairman/Non- Executive Director appointments.

3.2 Following consultation by the Chairman, additional meetings may take place in electronic format (email, telecommunication).

4. QUORUM

4.1 The quorum is at least three members present (or contributing to an electronic forum), one of whom must be a publicly elected Governor.

5. AUTHORITY

5.1 The Committee is authorised by the Council of Governors to carry out any activity within its Terms of Reference.

6. REPORTING MECHANISM

6.1 Minutes of each Committee will be formally recorded and submitted to the Council of Governors.

6.2 The Chairman should draw to the attention of the Council of Governors any matters relevant to the Committee's duties.

7. PROCESS

7.1 The Committee will:

i) on an annual basis monitor the performance of the Chairman and other Non-Executive Directors and make reports thereon to the Council of Governors when requested to do so by the Lead Governor or when in the opinion of the Nominations, Remuneration and Evaluation Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors;

ii) consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chairman and Non-Executive Directors;

iii) review the composition of the Board of Directors and the skill mix of the Non-Executive Directors from time to time.

iv) determine the processes for the selection of candidates for office as Chairman or other Non-Executive Director of the Trust having first consulted with the Board of Directors as to these matters and having regard to such views as may be expressed by the Board of Directors;

v) using the Trust's HR Services to seek candidates for office and to assess, shortlist and select for interview such candidates as are considered

appropriate and in doing so the Nominations, Remuneration and Evaluation Committee shall be at liberty to seek advice and assistance from persons other than members of the Committee or of the Council of Governors such as external organisations recognised as experts in recruitment and remuneration;

vi) to make recommendations to the Council of Governors of the candidate for appointment as Chairman or other Non-Executive Directors, as the case may be.

8. REVIEW

8.1 The Terms of Reference will be reviewed in ***January 2022*** or at the request of the Council of Governors by the Committee making recommendations to the Council of Governors as appropriate.

Company Secretary
January 2021

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 January 2021

Agenda item: 11.2

Subject:	Proposed process for the appointment of a lead governor

Prepared by:	Carrie Stone, Company Secretary and David Moss, Chairman
Presented by:	David Moss, Chairman and Carrie Stone, Company Secretary

Purpose of paper:	The Trust's Constitution states that the Council of Governors shall appoint one of the governors to be Lead Governor via a process agreed with the Council of Governors and the Company Secretary. The proposed process is set out in the attached paper.
Background:	The Directors and the Governors have distinct roles, but they share a common interest in ensuring that the Trust provides the best possible service to our patients and residents, based on shared values and effective governance. The Chair of the Trust chairs both the Board of Directors and the Council of Governors and leads in partnership working between the Board and the Council. The Lead Governor also has an important role in working with the Chair in the development of this partnership.
Key points for Council of Governors members:	The Council of Governors is asked to approve the proposed process for the appointment of a lead governor so that the Company Secretary can organise the appropriate action.
Options and decisions required:	To approve the proposed process for the appointment of the Lead Governor or make further amendments.
Recommendations:	To approve the attached Process.
Next steps:	To seek nominations from Governors in early April 2021.

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

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

PROPOSED PROCESS FOR THE APPOINTMENT OF A LEAD GOVERNOR

1. INTRODUCTION – THE CONTEXT

The Directors and the Governors have distinct roles but they share a common interest in ensuring that the Trust provides the best possible service to our patients and residents, based on shared values and effective governance. The Chair of the Trust chairs both the Board of Directors and the Council of Governors, and leads in partnership working between the Board and the Council. The Lead Governor also has an important role in working with the Chair in the development of this partnership.

2. TERM OF OFFICE

The appointment as Lead Governor shall be for an initial period of a year or until they resign the position of Lead Governor by giving notice to the Chairman and Company Secretary in writing.

3. PROPOSED PROCESS

The Trust's Constitution states that the Council of Governors shall appoint one of the governors to be Lead Governor via a process agreed with the Council of Governors and the Company Secretary. The process proposed is as follows:

- The Company Secretary will request expressions of interest from members of the Council of Governors.
- All Governors who have expressed an interest in becoming Lead Governor shall submit to the Company Secretary a short statement (300 words maximum) on how they are suited to the role.
- The Company Secretary shall circulate by email all statements to members of the Council of Governors.
- Governors will return their vote via email.
- All emailed returns will be acknowledged by the Company Secretary and the result of the ballot will be reported formally at the next Council of Governors meeting.
- The above will be based on a 'first past the post' approach and the Governor with the highest number of votes will be appointed as Lead Governor.
- In the event of a hung vote, the Chairman would have the casting vote
- Candidates will be able to withdraw from the process at any time.
- A similar process would take place at the same time to appointment a Deputy Lead Governor.

4. PERSON SPECIFICATION FOR LEAD GOVERNOR OF THE COUNCIL OF GOVERNORS

The Role

The main duties of the Lead Governor are to:

- Facilitate a good working relationship among Governors with the support of the Company Secretary.
- Provide additional assurance to Governors gained through meetings with the Chairman.
- Provide a regular link to the Chairman and reflect the views of Governors on issues affecting the Trust and the Governors' role.
- Contribute, along with the other governors, to the annual appraisal of the Chairman by the Senior Independent Director in accordance with the process determined by the Council of Governors.

- Act as a point of contact for NHS Improvement should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate. This should only happen in exceptional circumstances.
- Be the conduit for raising with NHS Improvement any Governor concerns that the Foundation Trust is at risk of significantly breaching the Conditions of its Provider Licence, having first made every attempt to resolve any such concerns locally.
- Be a point of contact when Governors wish to seek advice and/or raise issues.
- Chair such parts of meetings of the Council of Governors which cannot be chaired by the Chairman, Vice Chair or another Non-Executive Director if there is a conflict of interest in relation to the business being discussed.

The Person Specification

Any Governor can stand to be Lead Governor. However, it is preferable for this to be a publicly elected governor if possible.

To be able to fulfil this role effectively the Lead Governor should:

1. Have the confidence of Governor colleagues.
2. Be willing to challenge respectfully and constructively.
3. Have the ability to influence and negotiate.
4. Be able to present well-reasoned argument.
5. Be committed to the success of University Hospitals Dorset NHS Foundation Trust.
6. Have the ability to Chair meetings.
7. Understand the role of NHS Improvement and the basis on which NHS Improvement may take regulatory action.
8. Demonstrate an understanding of the Trust's Constitution, the role of the Council of Governors and its committees.
9. Be able to commit the time necessary to undertake the role.

5. THE CONCLUSION

The Council of Governors is asked to approve the above process so that the Company Secretary can organise the appropriate action.

David Moss
Chairman

Carrie Stone
Company Secretary

December 2020

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 January 2021

Agenda item: 11.3

Subject:	Policy for Engagement with the Council of Governors

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

Purpose of paper:	To NOTE the Policy for Engagement with the Council of Governors
Background:	This Engagement Policy has been developed in recognition of the recommendations in the NHS Foundation Trust Code of Governance to address engagement between the Board of Directors and the Council of Governors.
Key points for Council of Governors members:	The key points are: • The paper fulfils the requirement of Monitor's Code of Governance (provision A.5.6); • Reflects Annex 6, Section 6: Governors and Directors: Communication and Conflict of the Trust's Constitution, previously approved; • It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust; • Informal and frequent communication between Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides; • Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively; • Paragraph 6.1 gives discretion to the Chairman to manage questions from the governors in the light of other Board business; • Responses to questions put by individual governors to the Board will be reported in a subsequent edition of the Governors' weekly newsletter; • The chairmen of the Committees of the Board to attend Governor briefings to discuss the work of their respective Committees to assist Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board. • Section 8 describes the process for raising concerns/dispute resolution procedure, as per the Constitution.

Options and decisions required:	To note.
Recommendations:	To note
Next steps:	To add to the Trust's website.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Board of Directors	27 01 2021

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

ENGAGEMENT POLICY:

THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 This Engagement Policy has been developed in recognition of the recommendations in the NHS Foundation Trust Code of Governance (A.5.6) to address engagement between the Board of Directors and the Council of Governors. The principles in this policy may be applied to engagement between the Council of Governors and committees of the Board of Directors.

1.2 The engagement between the Council of Governors and the Board of Directors is enshrined within the Constitution Annex 6, Section 6: Governors and Directors: Communication and Conflict. This describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal and formal communications between the Council of Governors and the Board of Directors.

2 Purpose

2.1 This Engagement Policy outlines the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:

2.1.1 the performance of the Board of Directors;
2.1.2 compliance with the Trust's Provider Licence; or
2.1.3 other matters related to the overall wellbeing of the Trust.

3 Definitions

3.1 In this Policy the following definitions shall apply:

Board of Directors	means the Board of Directors as constituted in accordance with the Constitution
Chairman	means the chairman of the Trust appointed in accordance with the Constitution
Chief Executive	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution
Company Secretary	means the Company Secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust
Constitution	means the Constitution of the Trust
Council of Governors	means the Council of Governors of the Trust as constituted in accordance with the Constitution
Director	means a director on the Board of Directors

Governor	means a member of the Council of Governors, being either an elected or an appointed Governor
Independent Regulator	he independent regulator of foundation trusts known as Monitor, as provided by Section 61 of the 2012 Act
Lead Governor	means one Governor appointed by the Council of Governors to communicate directly with Monitor in certain circumstances
Provider Licence	means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006
Senior Independent Director	means the Non-Executive Director appointed by the Board of Directors
Trust	means the University Hospitals Dorset NHS Foundation Trust

4 Informal Communications

4.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

4.2 The Chairman shall use reasonable endeavours to encourage effective informal methods of communication including:

i) participation of the Board of Directors in the induction, orientation and training of Governors;

ii) development of special interest relationships between Non-Executive Directors and Governors;

iii) discussions between Governors and the Chairman and/or the Chief Executive and/or Directors through the office of the Chief Executive or a nominated officer;

iv) involvement in membership recruitment and briefings at public events organised by the Trust.

5 Formal Communications

5.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

5.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

i) specific requests by the Council of Governors will be made through the Chairman to the Board of Directors;

ii) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chairman but if the Chairman declines to raise any such issue the said Governor may nonetheless still raise it provided two thirds of the Governors present approve his request to do so. The Chairman shall then raise the matter with the Board of Directors and provide the response to the Council of Governors;

iii) joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate as determined by the Chairman (in his capacity as the Chairman of both the Board of Directors and the Council of Governors.

5.3 The Board of Directors may request the Chairman to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

5.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to:

i) the Board of Directors' proposals for the strategic direction of the Trust and the annual business plan;

ii) the Board of Directors' proposals for developments;

iii) Trust performance;

iv) involvement in service reviews and evaluation relating to the Trust's services; and

v) proposed changes, plans and developments for the Trust not covered by paragraph 5.4 above.

5.5 Some or all of the Board of Directors shall also present to the Council of Governors the Annual Accounts, the Annual Report including the Quality Account and any report of the Auditors in accordance with the terms of the Constitution and of the 2006 Act.

5.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:

i) attendance by the Directors at a meeting of the Council of Governors;

ii) provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors;

iii) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

iv) reporting the views of the Council of Governors to the Board of Directors though the Chairman, the Vice Chairman or the Senior Independent Director.

6 Other Communication

6.1 The Governors are welcomed to Part 1 meetings of the Board of Directors. There is an item on each Part 1 agenda "Questions from the Governors". These are requested by the Chairman, enabling individual governors to put questions to the Board. Verbal responses will be supplied as far as reasonable at the time of the meeting and reported in a subsequent edition of the Governors' newsletter. The Chairman has discretion to manage this item in the light of other Board business. It is also a matter for Governors as to whether the question is for a formal Board meeting or can be raised through the informal route. Board time is set aside for informal discussion between individual Governors and Board Members prior to commencement of the Part 1 meetings. Shortly following a Board of Directors meeting a briefing meeting takes place with the Chairman and Governors with the

purpose of informing the Governors as far as reasonable about the discussions conducted under the private session of the Board of Directors meetings. Approved Part 2 minutes of the Board of Directors are made available to Governors on a confidential basis. Where able, Executive and Non-executive Directors may attend these briefings to support the Chairman and impart further information if required. The Chairmen of the committees of the Board of Directors are also to attend meetings or briefings annually to discuss the work of the committees to assist the Council of Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board.

6.2 A weekly newsletter from the Chairman, Chief Executive and Company Secretary will also be sent to Governors containing relevant information and updates.

7 Senior Independent Director

7.1 The Senior Independent Director (SID) can act as an alternative source of advice to Governors from the Chairman.

7.2 The SID shall be available to Governors if they have concerns that contact through normal channels has failed to resolve any issues which have been raised or for which such contact is inappropriate.

8 Raising Concerns/ Dispute Resolution Procedure

8.1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances where they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective. Governors can raise concerns with the Company Secretary who may in the first instance be able to resolve the matter informally.

8.2 Where the Company Secretary has been unable to resolve the matter, the Lead Governor shall be the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Chairman on Governor matters.

8.3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Chairman (or Vice-Chairman if the dispute involves the Chairman) will endeavour to resolve the dispute informally, through discussions within the Council of Governors.

8.4 Within twenty-eight days of the Council of Governors of the Board of Directors resolving that a dispute exists with the other, the Company Secretary shall call a joint meeting to be held as soon as reasonably practicable within three months of the resolution. The joint meeting shall be held under the Trust's Board of Directors' Standing Orders, but the provisions of the Standing Orders of the Council of Governors in relation to interests shall apply to Governors attending the joint meeting as they apply to a Council of Governors meeting.

8.5 The joint meeting shall be chaired by the Chairman and the agenda shall be agreed with the Chief Executive. The joint meeting shall either recommend to each of the constituents the formula for resolving the dispute which each shall receive and consider formally as soon as practicable, or, if possible, shall agree the relevant issues and the possible way forwards.

8.6 If either constituent resolves to refer the issue to mediation, the Lead Governor and a second nominated Governor on behalf of the Council of Governors and the Chief Executive and the Vice-Chairman of the Board of Directors shall meet within twenty-eight days of such resolution to agree a mediator. In default of agreement, either constituent may resolve to refer the dispute for resolution by Monitor.

8.7 On the satisfactory completion of this disputes process the Board of Directors and the Council of Governors, as appropriate, shall implement any agreed actions.

8.8 The existence of the dispute shall not prejudice the duty of the Board of Directors in the exercise of the Trust's powers on its behalf.

8.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing Monitor that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors and that the Trust is not meeting the conditions of its provider licence. The Lead Governor will act as the conduit between the Council of Governors and Monitor.

9. Supporting Documents or Relevant References

9.1 Monitor – The NHS Foundation Trust Code of Governance (July 2014);
Monitor – Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors (August 2013);
UDHFT Code of Conduct for Board of Directors;
UDHFT Code of Conduct for the Council of Governors.

10. Conclusion

10.1 This policy will be made available to the Board of Directors and the Council of Governors.

CARRIE STONE
Company Secretary
October 2020

DAVID MOSS
Chairman
October 2020

The procedure for any such mediation shall be as follows:

1.3.1 A neutral person, being an *accredited mediator, (the "**Mediator**") shall be chosen by agreement between the two parties. Alternatively, either party may within seven days from the date of the proposal to appoint a mediator, or within seven days of notice to any party that the chosen mediator is unable and unwilling to act, apply to the Centre for Dispute Resolution ("**CEDR**") to appoint a Mediator.

1.3.2 The parties shall within seven days of the appointment of the Mediator agree a timetable for the exchange of all relevant and necessary information and the procedure to be adopted for the mediation. If appropriate, the parties may at any stage seek from CEDR guidance on a suitable procedure.

1.3.3 All negotiations and proceedings in the mediation connected with the dispute shall be conducted in strict confidence and shall be without prejudice to the rights of the parties in any future proceedings.

1.3.4 All information (whether oral or in the form of documents, tapes, computer disks etc) produced for, during, or as a result of, the mediation will be without prejudice, privileged and not admissible as evidence or discoverable in any litigation or arbitration relating to the dispute. This does not apply to any information which would in any event have been admissible or discoverable in any such litigation or arbitration.

1.3.5 The Mediator's reasonable fees and other expenses of the mediation will be borne by the Foundation Trust. The Foundation Trust will bear the reasonable costs and expenses of the participation in the mediation.

1.3.6 If the parties reach agreement on the resolution of the dispute that agreement shall be reduced to writing and shall be binding upon the relevant parties.

1.3.7 For a period of ninety days from the date of the appointment of the Mediator, or such other period as the parties may agree, neither party may commence any proceedings in relation to the matters referred to the Mediator.

1.3.8 If the parties are unable to reach a settlement at the mediation and only if both parties so request and the Mediator agrees, the Mediator will produce for the parties a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the Mediator suggests are appropriate settlement terms in all of the circumstances. Such opinion shall be provided on a without prejudice basis.

1.3.9 Subject to Conditions 1.3.6 and 1.3.7, should either party decide to pursue the dispute in a court, the Foundation Trust shall not be liable for any of the costs or expenses in relation to such proceedings.