University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: June 2023
Meeting Month: July 2023

Contents

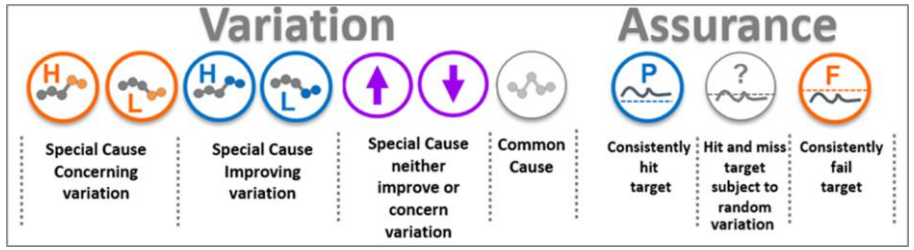
Performance at a Glance Indicators (1)

			standard	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
SAFE																
Quality	Presure Ulcers (Cat 3 & 4)			2	2	4	9	8	3	9	10	7	7	5	9	5
	Inpatient Falls (Moderate +)			1	5	7	5	3	2	5	9	3	3	5	2	7
	Medication Incidents (Moderate +)			0	2	2	1	0	2	1	0	1	0	0	0	2
	Patient Safety Incidents			1004	1205	1193	1096	1236	1216	1204	1166	1044	1201	1073	1190	1138
	Hospital Acquired Infections	MRSA		0	0	0	1	1	0	0	1	0	0	1	0	0
		MSSA		2	3	3	3	7	2	3	3	1	1	4	6	8
		C Diff		9	9	11	9	2	4	5	6	4	5	5	8	17
		E. coli		7	4	7	9	6	7	5	10	7	14	5	8	17
EFFECTIVE																
Mortality	HSMR (all Latest Mar 23	(source Dr Foster)		100.36	106.70	109.40	109.60	119.60	118.60	114.40	105.10	102.70	101.80			
	Patient Deaths	YTD		236	234	226	225	256	256	294	273	217	259	238	228	215
	Deaths within 36hrs of Admission			37	30	29	29	41	37	50	38	37	32	36	41	34
	Deaths within readmission spell			35	21	22	21	21	17	24	23	23	16	22	21	18
CARING																
	Complaints Received			80	78	83	90	98	100	75	92	84	86	73	95	91
	Complaint Response Rate (55 Days)			66.7%	67.7%	63.9%	56.6%	66.7%	58.7%	62.3%	52.5%	51.4%	47.4%	45.5%	45.5%	38.5%
	Friends & Family Test			88.3%	86.0%	90.4%	90.0%	89.8%	90.2%	87.8%	91.1%	92.7%	90.3%	90.9%	91.8%	91.0%
WELL LEAD																
Safety	Risks 12 and above on Register			34	34	35	38	37	35	37	38	41	38	38	40	43
	Risks 15 and above on Register			18	17	19	20	19	19	19	20	20	19	19	20	21
	Red Flags Raised*			45	86	128	142	107	74	84	41	43	38	21	43	25
People	Turnover			14.80%	14.50%	14.50%	14.70%	14.60%	14.70%	14.80%	14.94%	14.72%	13.90%	13.83%	13.66%	13.42%
	Vacancy Rate			5.68%	6.03%	8.88%	6.19%	7.96%	8.82%	7.3%	7.0%	6.4%	6.0%	5.8%	6.2%	6.6%
	Sickness Rate			5.1%	5.8%	4.7%	4.9%	5.7%	5.2%	6.4%	4.8%	4.7%	4.8%	3.9%	3.7%	3.9%
	Statutory and Mandatory Training			84.40%	85.54%	87.11%	86.75%	85.32%	85.80%	85.92%	86.31%	86.81%	86.98%	87.84%	88.45%	89.41%

Performance at a Glance Indicators (2)

		standard	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
RESPONSIVE																
RTT	18 week performance %	92%	58.2%	58.3%	57.1%	54.9%	55.5%	56.1%	55.1%	55.4%	54.3%	53.8%	52.6%	54.3%	55.1%	
RTT	Waiting list size	44,508	73,932	75,502	75,065	72,860	70,918	71,161	70,259	71,230	72,522	72,770	74,557	74,500	74,483	RAG based on trajectory
RTT	No. patients waiting 26+ weeks		20,428	20,244	21,326	21,172	20,227	20,765	21,024	21,726	22,109	22,248	24,223	24,230	22,499	
RTT	No. patients waiting 52+ weeks		4,493	4,170	4,010	3,559	3,468	3,634	3,472	3,565	3,861	4,100	4,380	4,813	4,574	RAG based on trajectory
RTT	No. patients waiting 65+ weeks		1,714	1,405	1,464	1,420	1,449	1,342	1,195	1,127	1,147	1,070	1,249	1,242	1,053	
RTT	No. patients waiting 78+ weeks	0	520	492	502	504	513	487	473	395	274	96	112	97	32	RAG based on trajectory
RTT	No. patients waiting 104+ weeks	0	118	100	95	76	63	37	25	10	0	0	0	0	0	RAG based on trajectory
Theatre	Theatre utilisation (capped) - main	98%	78%	74%	75%	75%	69%	75%	73%	71%	71%	65%	72%	73%	73%	
Theatre	Theatre utilisation (capped) - DC	91%	73%	69%	69%	70%	74%	74%	69%	69%	67%	57%	69%	74%	73%	
Theatre	NOFs (Within 36hrs of admission - NHFD)	85%	2%	12%	18%	8%	40%	52%	43%	49%	24%	67%	54%	33%	37%	
Outpatients	**Outpatient metrics**															
Outpatients	Overdue Follow up Appts		25,671	32,621	33,268	33,840	32,999	32,757	33,369	34,863	34,756	34,302	31,778	31,057	30,594	
Outpatients	% DNA Rate	5%	8.3%	8.3%	8.0%	7.4%	6.8%	6.5%	7.5%	7.5%	6.5%	7.1%	7.6%	6.5%	6.1%	
Outpatients	Patient cancellation rate		10.7%	11.2%	10.5%	11.4%	11.0%	10.5%	12.3%	10.6%	10.8%	9.2%	8.9%	11.3%	11.6%	
Outpatients	% non face to face (telemedicine) attendances	25%	22.9%	22.5%	21.8%	21.1%	20.4%	20.0%	20.2%	20.8%	21.3%	18.5%	18.6%	18.6%	17.5%	
DM 01	**Diagnostic Performance (DM01)**															
DM 01	% of >6 week performance	1%	19.5%	20.2%	22.6%	20.0%	16.4%	11.0%	13.6%	10.7%	7.4%	7.0%	8.4%	6.0%	7.7%	
Cancer	28 day faster diagnosis standard	75%	66.9%	63.6%	62.9%	64.7%	63.1%	59.6%	68.4%	65.0%	71.0%	75.4%	71.2%	70.2%	71.9%	*June cancer position predicted and not finalised*
Cancer	62 day standard	85%	73.4%	66.2%	65.9%	71.2%	69.4%	64.3%	63.4%	63.6%	61.9%	65.4%	67.0%	62.7%	60.2%	
Emergency Dept	4 hour care standard												61.6%	65.9%	61.7%	
Emergency Dept	Arrival time to initial assessment	15	18.0	21.6	30.0	15.0	16.0	15.0	20.5	11.0	15.0	13.0	16.0	19.0	22.0	
Emergency Dept	Clinician seen <60 mins %		20.0%	20.9%	26.6%	26.0%	25.5%	24.3%	21.8%	31.6%	25.7%	26.1%	31.6%	27.6%	35.6%	
Emergency Dept	Patients >12hrs from DTA to admission	0	105	97	103	129	295	157	343	234	294	211	220	82	13	
Emergency Dept	Patients >12hrs in dept		769	879	779	886	1292	1074	2000	1108	1443	1238	849	637	504	
SW AST	Ambulance handovers		3696	3758	3743	3657	3716	3855	3545	3602	3360	3988	4001	4102	4015	
SW AST	Ambulance handover >60mins breaches		629	642	445	547	666	583	1568	733	859	900	698	345	383	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	93.4%	93.6%	93.4%	92.8%	94.2%	92.7%	93.3%	93.1%	94.1%	94.5%	93.6%	92.3%	94.4%	
Patient Flow	Stranded patients:															
Patient Flow	Length of stay 7 days		539	543	577	567	605	550	522	564	582	543	523	502	480	
Patient Flow	Length of stay 14 days		360	357	400	397	421	375	332	366	387	355	337	322	294	
Patient Flow	Length of stay 21 days	108	256	255	295	303	315	281	228	250	269	255	235	223	199	
Patient Flow	Non-elective admissions		5802	5778	5367	5472	5535	5817	5956	5693	5165	6203	5690	6288	6347	
Patient Flow	> 1 day non-elective admissions		3633	3652	3396	3475	3578	3676	3905	3673	3202	3881	3612	3826	3783	
Patient Flow	Same Day Emergency Care (SDEC)		2168	2126	1971	1996	1956	2141	2050	1979	1963	2316	2078	2458	2560	
Patient Flow	Conversion rate (admitted from ED)	30%	26.90%	26.50%	26.30%	27.60%	25.80%	29.10%	28.30%	30.90%	27.79%	28.30%	29.70%	29.90%	31.60%	

Statistical Process Control (SPC) – Explanation of Rankings



Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: none
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
~	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
○				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Quality Outcomes & Safety Patient Experience

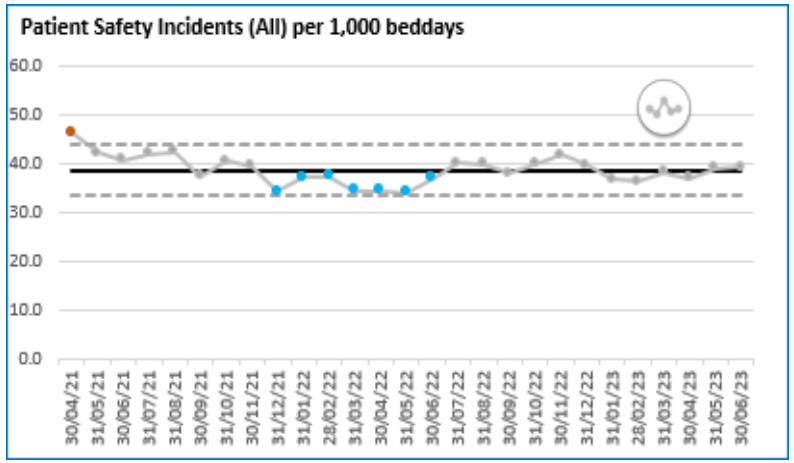
University Hospitals Dorset
NHS Foundation Trust


Professor Paula Shobbrook
Chief Nursing Officer/ Deputy CEO
Dr Peter Wilson
Chief Medical Officer

Operational Leads:
Jo Sims – Associate Director Quality, Governance and Risk
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Clinical practice and Patient Experience)
Sean Weaver – Clinical Lead for Mortality
Fiona Hoskins – Deputy Chief Nursing Officer (Workforce & Safeguarding)
Sarah Macklin - Care Group Director of Operations, Women's, Children, Cancer and Support Services
Lorraine Tonge - Director of Midwifery
Mr Alex Taylor - Clinical Director

Committees:
Quality Committee

Quality (1) – Safe



Background/target description

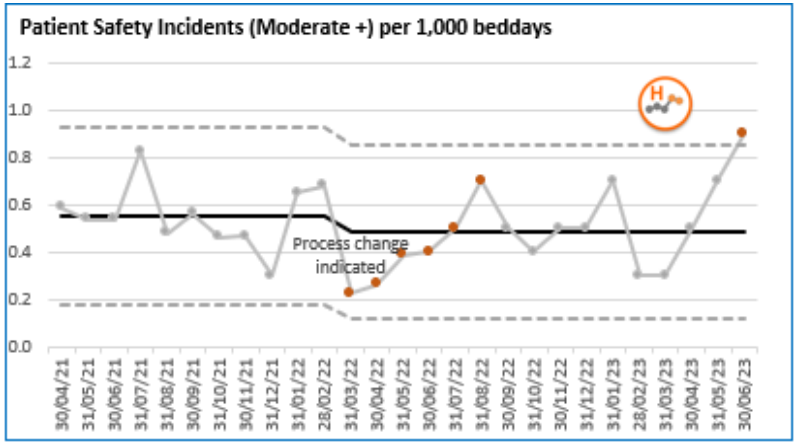
To improve patient safety.

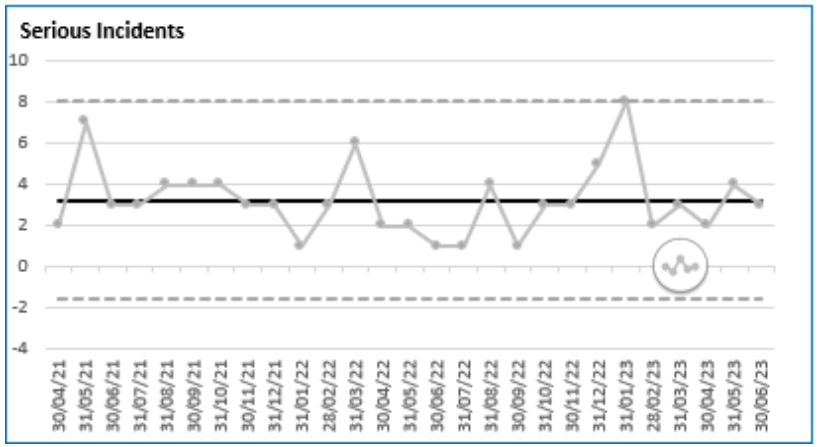
Performance

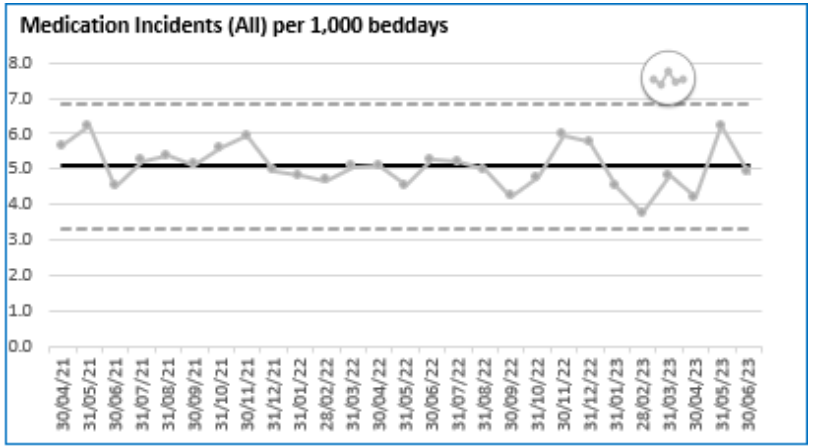
- Three (3) externally reported incidents reported in month (June 23).
- No significant trends or changes in metrics in month

Key Areas of Focus

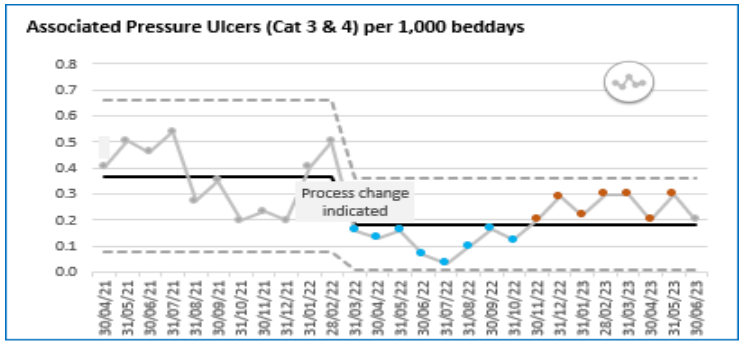
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

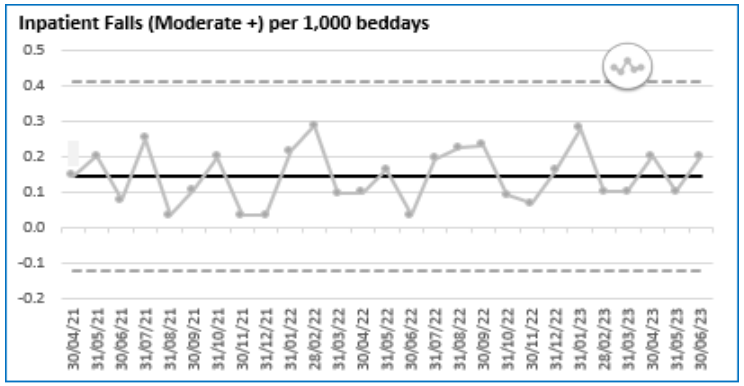


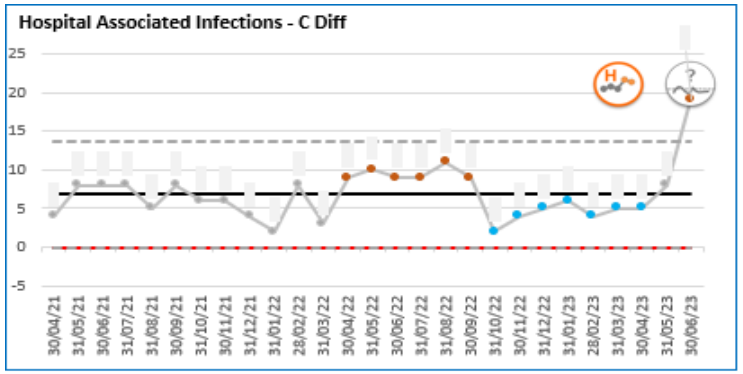




Quality (2) – Safe







Background/target description

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

Performance

Clinical practice:

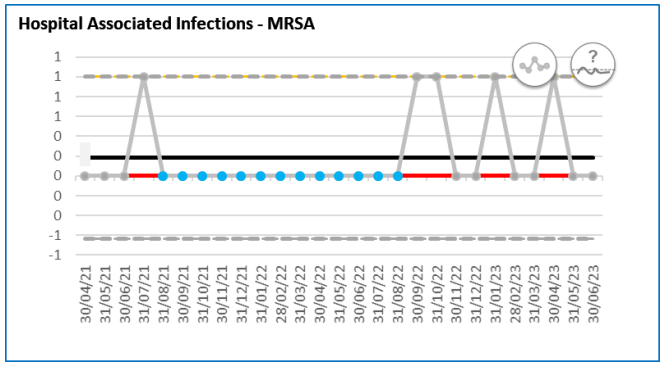
- There was a reduction in reported Pressure Ulcers in month with five new category three pressures ulcers reported which are following the appropriate investigation.
- There was an increase in number of serious falls incident in month with six falls reported. Five of which were severe and one documented as a moderate harm. These falls are following the appropriate scoping and investigation process.

IPC

- June saw reduction in ward closures as seasonal viral infections declined.
- New guidance for COVID screening appears to be largely adopted across UHD with some local exceptions e.g. Haematology
- New A-Z pathogens out for consultation, as is IC Principles Policy
- Increase in number of C. difficile cases identified - community and trust associated, which is in a national picture.. IPC Team working to understand trends.
- E. coli increase seen June an but seasonally increased - thought to be due to weather, increase in UTI as source.
- IPC nurse consultant interview process in progress

Key Areas of Focus

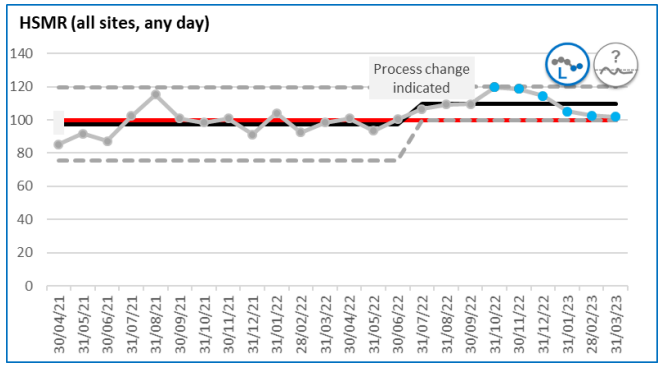
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

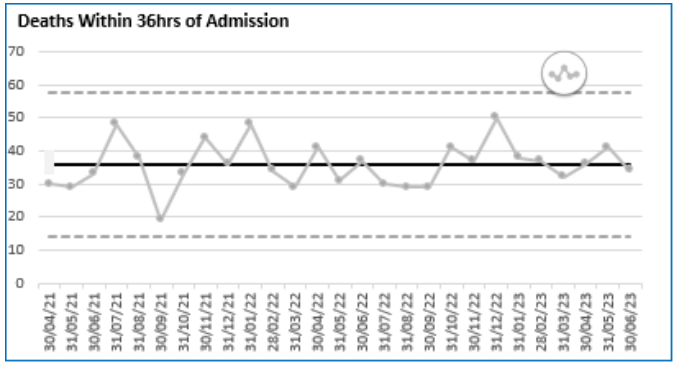


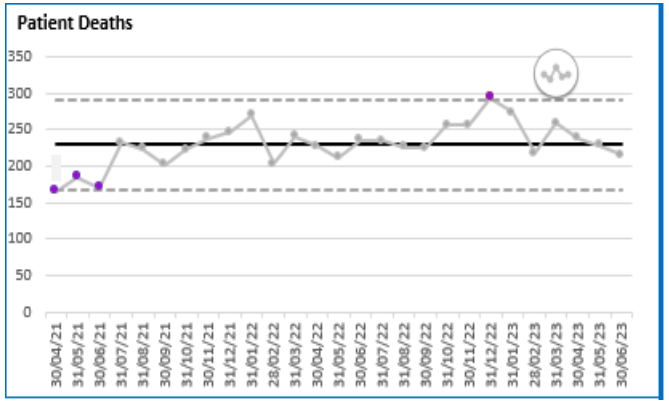
Hospital Associated Infections Summary for IPR

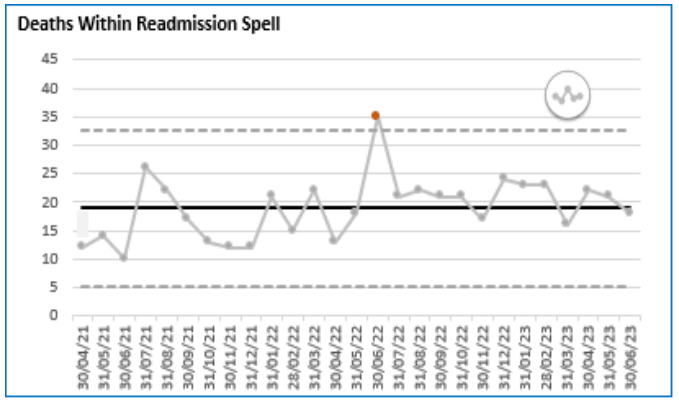
Month	C Diff	E Coli	MRSA	MSSA
Jun-22	9	7	0	2
Jul-22	9	4	0	3
Aug-22	11	7	0	3
Sep-22	9	9	1	3
Oct-22	2	6	1	7
Nov-22	4	7	0	2
Dec-22	5	5	0	3
Jan-23	6	10	1	3
Feb-23	4	7	0	1
Mar-23	5	14	0	1
Apr-23	6	7	1	5
May-23	8	8	0	6
Jun-23	19	17	0	8

Quality (3) – Effective & Mortality









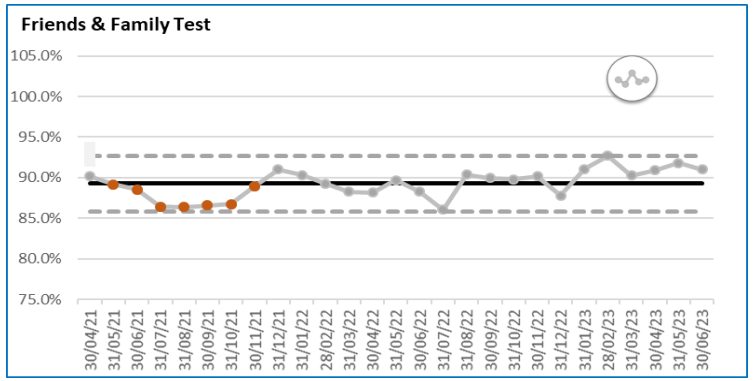
Please see the separate 'Mortality Update' which has been submitted to the Board outlining the imminent development of a new suite of mortality metrics. This new development will be the standard mortality output for all committees – Board, IPR and Quality Committee.

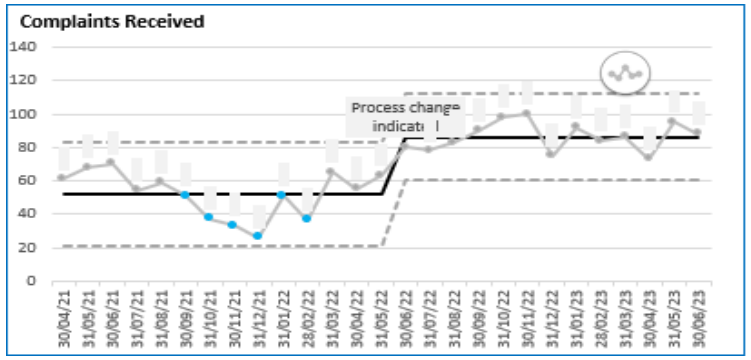
The headline mortality figure that we will report and which will align with the key metric in Patient First will be HSMR for the whole of UHD.
We will support this with an evolving suite of relevant metrics which will adapt to need and any risks.

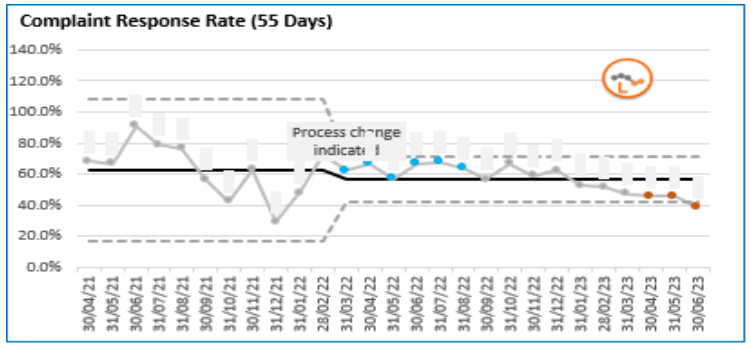
As previously reported to board, all formally reported mortality metrics are at least 5 months old and any trends are about a year old. As a trust we need to be mindful and sighted of this data and we will also use some more contemporaneous sources from the medical examiner and learning from deaths review.

We aim to have this reporting ready for the August output.

Quality (3) – Caring







PALS and Complaints Data for June 23:

Overview:

- 456 PALS concerns raised
- 76 new formal complaints (remain within our control measures)
- 13 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in June were 75.

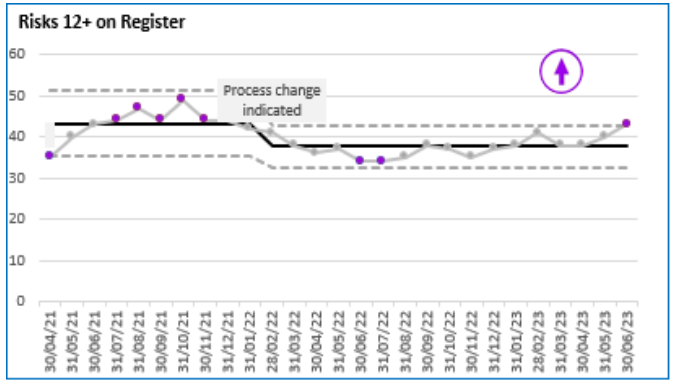
- Key themes from PALS and complaints:
  - Quality – clinical standards
  - Safety – errors, incidents and staff competencies
  - Communication – absent or incorrect
  - Respect – caring and patient rights

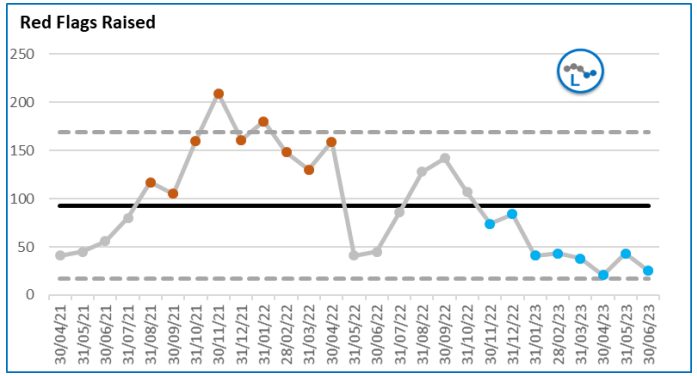
Alert: Additional resource to support responding to and closing complaints within the 55-day response has been recruited, some initial progress has been made. Further changes and recruitment planned to address these further.

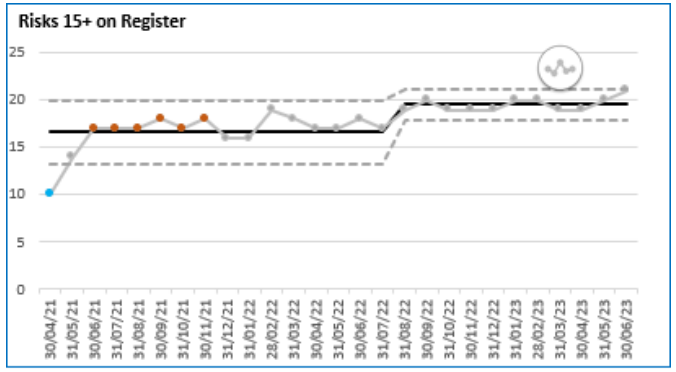
Friends and Family Test (FFT)
A return to normal response levels for FFT is noted and reported at 91% in June 2023.

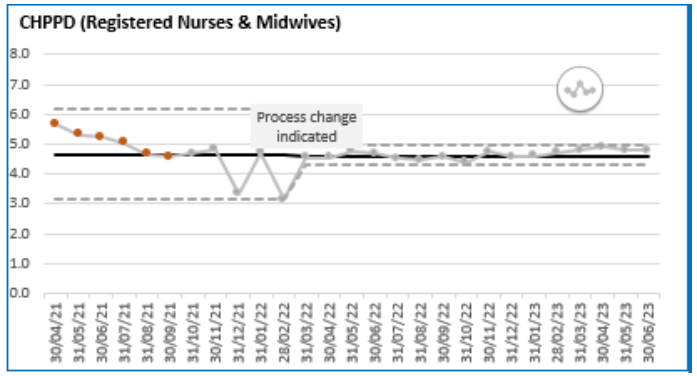
Mixed Sex Accommodation Breaches
There were no reported MSA incidents in June 2023

Quality (4) – Well Led









Performance

- CHPPD (Care Hours Per Patient Day) for registered nurses and midwives in June 2023 aggregated remained at 4.8, Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- June's red flag data shows that 25 on shift flags were raised. No critical staffing incidents were reported showing that all flags were mitigated, and safe staffing maintained.

Key Areas of Focus

- Risk register being aligned to new Committee structure and UHD Accountability Framework (approved May 23)
- Updated Risk Management Strategy approved at QC and Board in June 23. Revised Risk Appetite Statement being developed
- Additional guidance on identification and articulation of controls has been shared with CGG and TMB.
- Risk register update provided in Quality Committee, TMB, and Board report.
- BDO Internal Audit report on Risk Maturity to be presented to Audit Committee. Positive assurance.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) June 2023

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15369	77233.7	76825.4	99.5%	5.0
Bournemouth & Christchurch	15600	74741.7	72335.9	96.8%	4.6
UHD Total	30969	151975.3	149161.4	98.1%	4.8

Maternity (1)

Executive Owner: Paula Shobbrook (Chief Nursing Officer / Deputy CEO)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge Director of Midwifery / Mr Alex Taylor Clinical Director

CQC Maternity Ratings UHD Assessment 2019 and Oct 2022.	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	Inadequate	Inadequate	GOOD	OUTSTANDING	OUTSTANDING	Inadequate
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)						73.2%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)						89.3%

National position & overview

- **The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview**
- **The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our Maternity Safety Self Assessment and Ockendon 1 requirements**
- **There are a number of items which require narrative rather than graphic benchmarking and these are described below**

Findings of review of all perinatal deaths using the national monitoring tool

MBRRACE reportable cases:

There have been no reportable cases for MBRRACE in June .

However overall year to date figures remain high , above expected range and therefore in agreement with the ICB there will be an external review. The months of April and May will be revied by Somerset Trust.

Findings from this review will be shared with the Trust Board.

Early theme identified of reduced fetal movements and action has been taken to increase awareness of the importance of reduced fetal movements.

Matters for Board information and awareness

Incidences to note:

Top 3 incidences

1. Insufficient numbers of healthcare professional :
- Causing disruption in service and delay in care.
- Training compliance standards not being met
- 1 Opel 4 – no harm to patients noted

2. Avoidable term admissions to NICU at 5.5% (<6% above national average above regional average of 5%) :
- In depth review in progress no early theme identified .

3.Telecommunications failure :
- 13 incidences report of call bell system alerts
- Fault on system identified by the company
- SOP followed and patient safety maintained
- Ongoing monitoring by the estates team
- Risk identified on risk register (Low risk)

Trust Board Reading room
- Midwifery workforce 6 monthly report
- Final SI report L98396

Progress in achievement of Year 5 Maternity incentive scheme

MIS year 5

Year 5 standards have been released.

There has been extension to the safety standards with additional elements to achieve.

Saving babies lives element 6 outlines pathways which are multi disciplinary and will require trust wide pathway and response.

Good progress is being made on recording of all training on BEAT/Green Brain however this standard now requires training to be consistent over 12 months of 90 %. As our training figures from January to June have not met this standard, we are unable to achieve full compliance to the scheme however maternity safety remains the same priority to all of the team.

Work continues on all safety standards with monthly assurance meetings to monitor compliance .

The national team are reviewing standard 6 saving babies' lives (SBL) standard 8 training and standard 9 Board assurance and a further update will be provided to trusts on these elements.

Maternity (2)

Executive Owner: Paula Shobbrook (Chief Nursing Officer)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge
Director of Midwifery / Mr Alex Taylor Clinical Director

Maternity Perinatal Quality Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	23-Jan	23-Feb	23-Mar	Apr-23	May-23	Jun-23
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	1.60%	1.40%	0.60%	3.1%	2.70%	4.2%
	Obstetric haemorrhage >1.5L	>2.6 %	4.20%	2.10%	4.30%	2.10%	3.0%%	3.7%
	Term admissions to NNU	National <6%, Regional <5%	5.80%	3.40%	6.20%	5.9%	6.50%	0.055
	Apgar < 7 at 5 minutes	<1.2 %	2.30%	2.40%	1.10%	2.3%	0.0%	1.10%
	Stillbirth number	Actual	0	1	0	4	2	0
	Stillbirth number/rate (per 1,000)	> /1000	0	3	0	13.29	7	0
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:23	01:23	01:25	01:25	01:24	01:24
Feedback	Number of compliments (Smiles via Badgernet)		62	18	43	42	37	41
	Number of concerns (PALS)		0	2	0	0	0	4
	Complaints	3	2	0	4	2	3	2
	FFT Repsonse -returns as % of deliveries not mandated now)			12%	40%	43%	46%	87%
Training	UHD Mandatory training - women's health	90%	79%	87%	86%	82%	84%	86%
	PROMPT/Emergency skills all staff groups	90%	96%	94%	94%	82%	82%	84%
	K2/CTG training all staff groups	90%	89%	85%	85%	91.76%	96%%	94%
	CTG competency assessment all staff groups	90%	89%	not known	not known	91.76%	96%%	94%
	Core competency framework compliance	90%	92%	not known	84%	84%	87%	89%
	Coroner Reg 28 made directly to the Trust	nal <6%, Regiona	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y (CQC)	Y (CQC)	Y (CQC)	Y (CQC)	Y(CQC)	Y(CQC)

Data and Targets

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

Performance

There are 2 areas currently flagging as red RAG rated :

- 3rd/4th degree tear overall rate :
- Obstetric haemorrhage >1.5L

There are 2 areas currently RAG rated as amber

- Term admissions to NNU - deep dive in progress
- Training –ongoing challenges to meet 90% compliance due to staff vacancies.

Improvement continues in the *Apgar <7 at minutes* metric has been noted following staff training

Key Areas of Focus

3rd/4th degree tear overall rate : performance for this metric has been reviewed and identified as not concerning as the rate is within normal range variation but has been red rated this month at 4.2% . The national rate is 3.5%.

Obstetric haemorrhage >1.5L : performance for this metric has been reviewed and identified as not concerning as the rate fluctuates but this will be monitored in next few months.

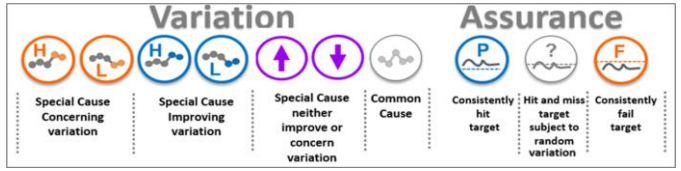
Term admissions to NNU : Avoidable term admissions to NICU (5.50%) is below the national average of <6% but above the region average of 5.0% . There have been 13 admissions.
Avoidable term admissions to NNU will be the subject of a deep dive with both the ODN and ICB and findings will be presented to the board.

Training
Not meeting 90% compliance for PROMPT and K2 CTG training- ongoing work with the team to improve this standard.

Performance at a glance
Quality - Key Performance Indicator Matrix

UHD Quality

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Jun 23	0.2	-			0.2	0.0	0.4
Inpatient Falls (Moderate +) per 1,000 beddays	Jun 23	0.2	-			0.1	-0.1	0.4
Medication Incidents (Moderate +) per 1,000 beddays	Jun 23	0.1	-			0.0	-0.1	0.2
Medication Incidents (All) per 1,000 beddays	Jun 23	4.8	-			5.1	3.3	6.9
Patient Safety Incidents (All) per 1,000 beddays	Jun 23	39.5	-			38.6	33.4	43.9
Patient Safety Incidents (Moderate +) per 1,000 beddays	Jun 23	0.9	-			0.5	0.1	0.8
Serious Incidents	Jun 23	3				3	-2	8
Never Events	Jun 23	0	-			0	-1	1
Hospital Associated Infections - MRSA	Jun 23	0	0			0	-1	1
Hospital Associated Infections - MSSA	Jun 23	8	0			4	0	8
Hospital Associated Infections - C Diff	Jun 23	19				7	0	14
Hospital Associated Infections - E Coli	Jun 23	17	0			7	-2	16
Risks 15+ on Register	Jun 23	21	-			20	18	21
HSMR (all sites, any day)	Mar 23	101.8	100.0			109.8	99.6	120.0
Mixed Sex Accommodation Breaches	Jun 23	0	0			4	-15	22
Complaints Received	Jun 23	88	-			86	60	112
Complaint Response Rate (55 Days)	Jun 23	38.5%				56.8%	42.4%	71.3%
Friends & Family Test	Jun 23	91.0%	-			89.3%	85.8%	92.7%
			0					
Patient Deaths	Jun 23	215	-			229	168	291
Deaths Within 36hrs of Admission	Jun 23	34	-			36	14	57
Deaths Within Readmission Spell	Jun 23	18				19	5	33
Risks 12+ on Register	Jun 23	43				38	33	43
Red Flags Raised	Jun 23	25				93	17	169
CHPPD (Registered Nurses & Midwives)	Jun 23	4.8				4.6	4.3	5.0



Our People

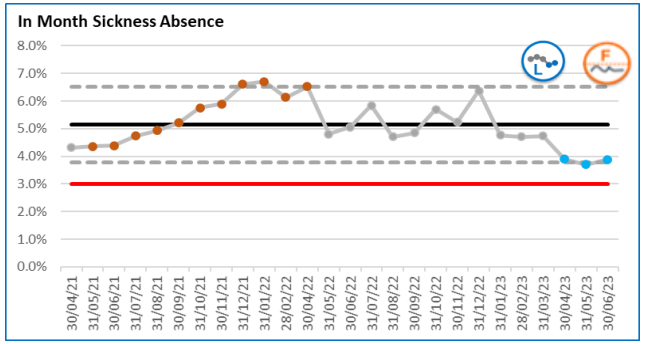
Karen Allman
Chief People Officer

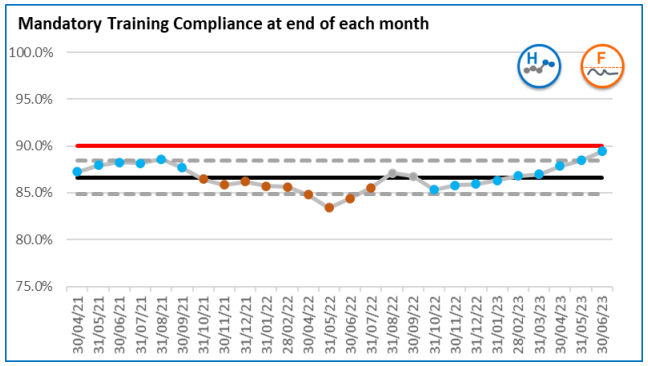
Operational Leads:
Irene Mardon - Deputy Chief People Officer

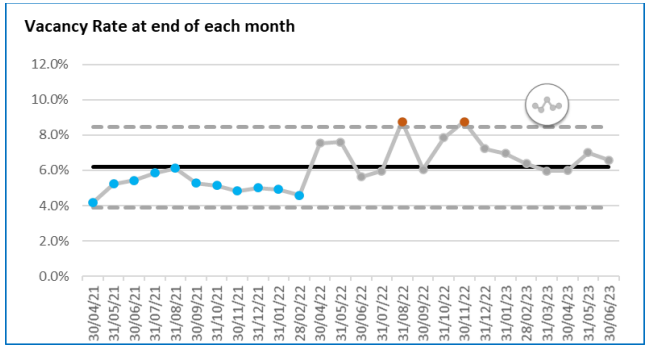
Committees:
People and Culture Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Workforce (1)







Performance

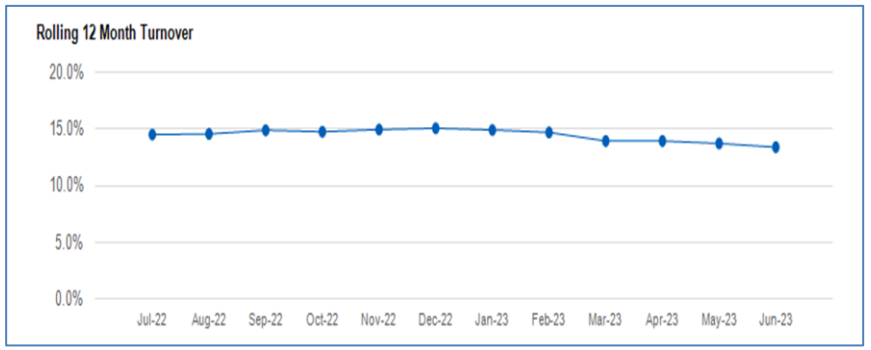
- Rolling 12 month Turnover rate (excluding fixed term temp) is at 13.4%, which is a slight reduction on last month and continues the downward trend.
- In month sickness absence for June 2023 was at 3.9%, slightly up from 3.7% previous month. Latest rolling 12 month rate (as at end of June 2023) is 4.9% which is a reduction on the previous month.
- Mandatory Training has improved slightly to 89.4% as at end of June 2023 but is still under the 90% across all sites.
- Latest vacancy position is 6.6% (June 2023). 10 Internationally Educated Nurses arrived in June, from Nigeria, India, Philippines, Ghana and Sri Lanka. The number of Non- Medical Starters was lower in June than in previous months, with half of those being internal moves. A new record of job offers was made in June for medical starters
- Appraisal compliance for values based as at end of June is 12.4%. Medical & Dental is 62.4%.
- Trust wide agency spend should be no more than 3.7% of the overall pay bill. Currently the Trust at M3 is at 4.61%

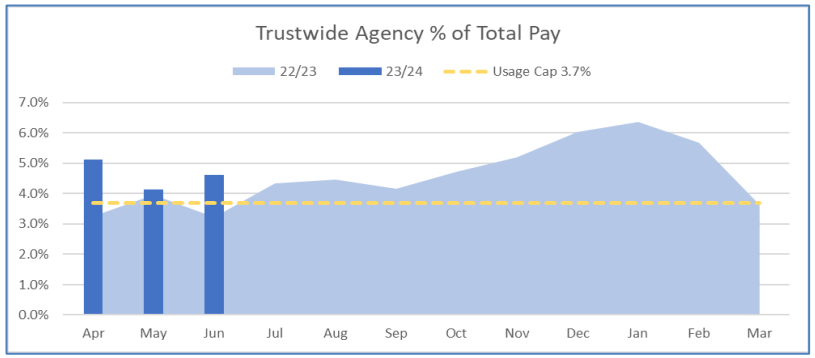
Underlying issues:

- Data continues to adjust as the ESR establishment work and data cleanse process continues.
- Agency spend has decreased in the Medical Care Group M2 8.18% to 7.98% in M3, The Surgical Care Group was 3.86% in M2 and is now 3.25% in M3. Women's, Children, Cancer and Support Services Care Group was 3.86% in M2 and is now 4.29% in M3. Surgical Care Group remains under 3.7% but has seen a rise in M3

Key Areas of Focus

Information Governance is currently below the 95% national compliance required – currently it is 92.1%.

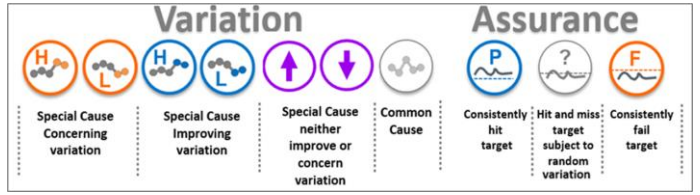




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Jun 23	6.6%	-			6.2%	3.9%	8.5%
In Month Sickness Absence	Jun 23	3.9%	3.0%	L	F	5.1%	3.8%	6.5%
Mandatory Training Compliance at end of each month	Jun 23	89.4%	90.0%	H	F	86.6%	84.8%	88.4%
Temporary Hours Filled by Bank	Jun 23	53.0%	-			53.8%	46.7%	60.9%
Temporary Hours Filled by Agency	Jun 23	24.0%	-			15.0%	12.6%	17.3%



Population Health and System Working

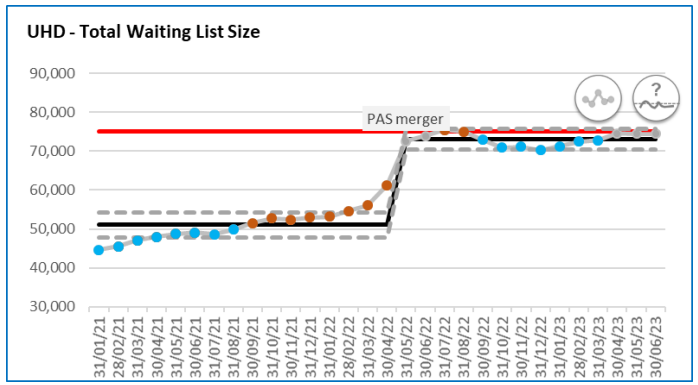
Mark Mould
Chief Operating Officer

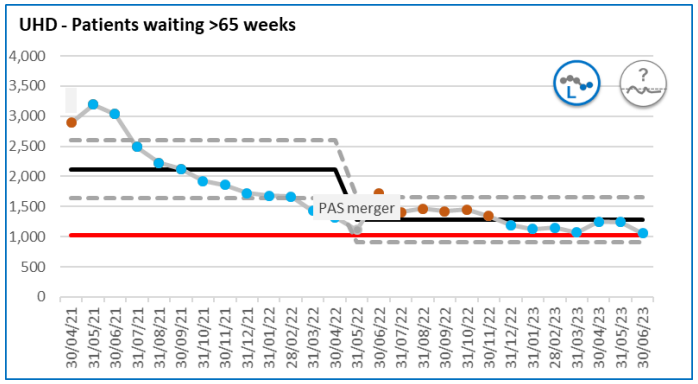
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Alex Lister – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Sarah Macklin – Group Director of Operations – Women's, Children, Cancer and Support Services
Leanna Rathbone – Group Director of Operations – Medical

Committees:
Finance and Performance Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Responsive – (Elective) Referral to Treatment)





	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	55.06%	
Waiting list size	51,491	74,483	17%
Waiting List size variance compared to Sep 2021 %	0%	44.7%	
No. patients waiting 26+ weeks		22,499	21%
No. patients waiting 40+ weeks		9,892	23%
No. patients waiting 52+ weeks (and % of waiting list)	6.1%	4,574	25%
No. patients waiting 65+ weeks (and % of waiting list)	1.4%	1,053	36%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	32	44%
No. patients waiting 104+ weeks (and % of waiting list)	0.0%	0	-
% of Admitted pathways with a P code		97.54%	

Data Description and Target

Total number of patients waiting on an RTT elective waiting list.
Number of patients on an elective RTT waiting list whose wait exceeds 78 weeks. National target 0 by March 2023.
Number of patients on an elective RTT waiting list whose wait exceeds 65 weeks. National target 0 by March 2024.

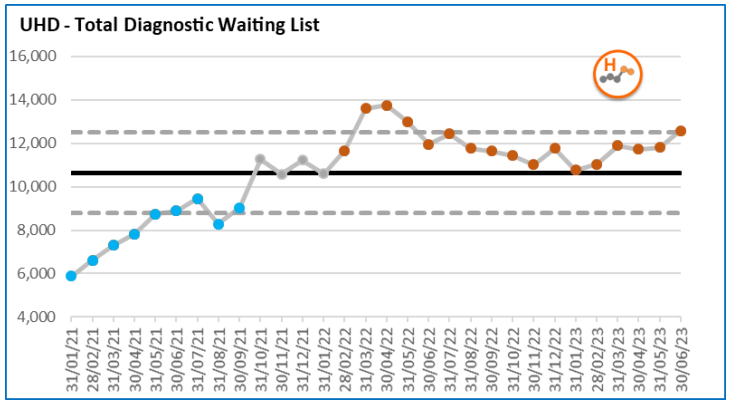
Performance

- 32 patients breaching over 78 weeks remain at the end of June; a reduction of 65 since May 23. Breaches are in 4 specialties: Trauma & Orthopaedics, Colorectal Surgery, Gynaecology and Community Paediatrics, School Age Neurodevelopment Service.
- The impact of industrial action in June meant that the Trust was not able to eliminate 78 week waits as planned, as cancer and clinically urgent patients were prioritised into outpatient and theatre capacity. Reduced preoperative assessment capacity in month has been mitigated by additional sessions running at weekends and prioritisation of patients for assessment.
- Two Orthopaedic 78-week breaches reported last month, due to waits for nickel-free orthopaedic joint replacements, are now both dated to come in.
- 1,053 patients are breaching 65 weeks at the end of June 2023. This is 30 above plan (1,023), however the variance to plan has reduced this month by 63. A sustained reduction in 65-week waits is being maintained.
- The total waiting list (PTL) was 74,483. This measure is not changing significantly; however, performance is 778 below the operational planning trajectory for June 2023 (75,261). Continuous validation of the waiting list is necessary to ensure data quality is maintained.

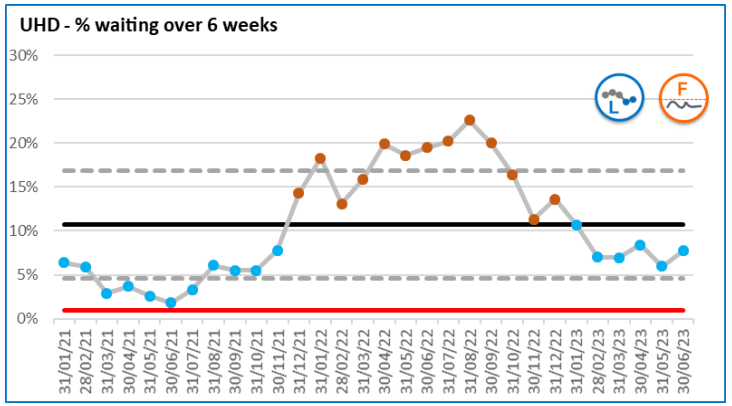
Key Areas of Focus

- Promoting excellence in the basics including extending the Trust's wait-in-line initiative to ensure capacity is used appropriately and an additional validation hub is planned in July in ENT services.
- Additional internal waiting list initiatives for both elective and cancer waits are scheduled in a range of services including Gynaecology, Community Paediatrics, Dermatology and Urology.
- Arrangements are being finalised to secure an Independent Sector Provider to provide additional School Age Neurodevelopment assessment capacity. This capacity is likely to be available in August 23.
- The Chief medical Officer and Chief Operating Officer are working with Care Group Medical Directors and Group Director of Operations to optimise our capacity for elective work during IA in July whilst maintaining patient safety and quality of care. It is anticipated that there will be a significant reduction in activity, however.
- Implementation of the enhanced pay rate scheme for theatre staff is supporting additional theatre sessions to run, whilst recruitment continues to onboard new starters.

Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)				
% of >6 week performance	*(6+ Weeks / Total)*	1%	975/12584	7.7%



Data Description and Target

Total number of patients waiting a diagnostics test
Number of patients whose wait for a diagnostic test exceeds 6 weeks. Target 1%

Performance

Consistent significant improvement in overall diagnostics (DM01) performance has been delivered since January 2023. May performance was 6.0% compared to 7.7% at the end of June. Further improvement is required to meet the 1% target.

Endoscopy improved again in month to 13.9% at the end of June (17.5% at the end of May).

Echocardiography performance has deteriorated moving from 10.6% in May to 14.9% in June.

- Heart failure remains the challenge in achieving DM01 but improvement continues through good list utilisation and additional lists from our staff. 25% increase in referrals in month.

Neurophysiology remains at 9.8% in June.

- Consultant vacancy has led to reduced capacity and longer waits within the department. There is ongoing use of locum cover and redistribution of other clinical work in the dept to manage performance.

Radiology performance has deteriorated since May (3.0%) to 5.4% in June .

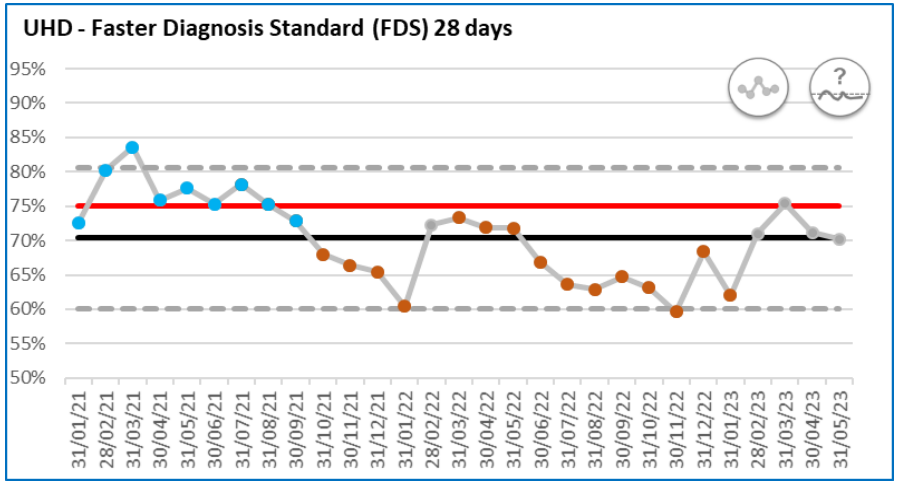
- Imaging – the target is not being achieved consistently, predominately due to ongoing reduction in cardiologist CT / MRI sessions. A locum cardiologist has now commenced and completing training; anticipated completion by August 2023.
- Increased numbers of ultrasound breaching patients due to BH and unfilled WLIs. Additional AECC provision in place to recover backlog.
- MRI scanning at the mobile unit situated at AECC has commenced.

Key Areas of Focus

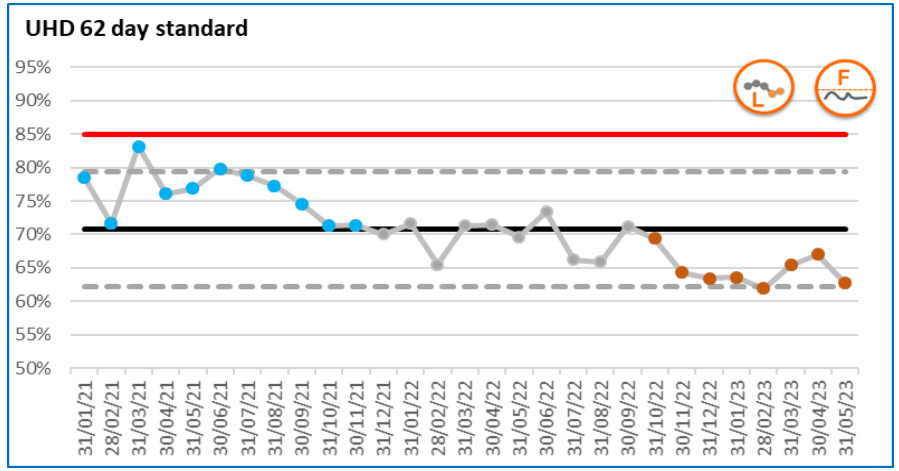
- Endoscopy: Ongoing insourcing requested from ERF for Q2 and Q3 in the form of 18WS and InHealth mobile unit. Workforce expansion plan underway to staff weekday lists at Wimborne.
- Dr Doctor to be integrated with e-Camis for Endoscopy with ongoing management of bookings team to ensure high utilisation (currently at 88%) and low DNAs. New report has been developed to pull utilisation data.
- Delivery of reduction in DNA using dedicated A&C support and recruitment campaigns continue in Echocardiology.
- Continued assistance from AECC planned in July for ultrasound and MRI recovery.
- Exploring potential move of cardiac CT/MR activity at UHD to DCH.
- Mitigation of the impact of industrial action in all modalities.

Responsive (Elective)
Cancer FDS 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
May Performance by Tumour Site (70.2%)



62-Day Standard (Target 85%)
May Performance by Tumour Site (62.7%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard 75%
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62d Standard 85%
- The number of 62-day patients waiting 63 days or more on their pathway.

Finalised May Performance

- 28 Day Faster Diagnosis Standard - Performance in May was 70.2% and fell below the mean (1.8% below the trajectory). 6 out of 14 tumour sites achieved the target but the Trust is inconsistently achieving the target and is yet to show evidence of statistical improvement. Recovery plans are in place for the remaining tumour sites.

- 62 Day performance in May decreased by 4.3% compared to the previous month to 62.7%. Treatment numbers were 17.2% lower compared to May 2022 (likely due to 3 bank holidays and industrial action in the month), which impacted on performance.

- The total number on the UHD PTL in May over 62 days increased to 352.

Predicted June Performance (un-finalised)

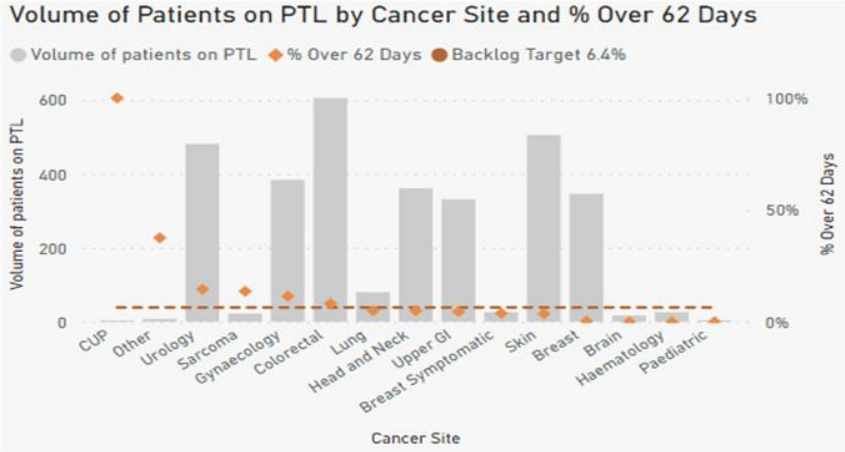
- 28 Day - June's performance is currently showing an increase of 1.7% to 71.9% (trajectory 73.5%). 6 out of 14 tumour sites achieved the standard, which is an increase of 2.

- 62 Day - The provisional performance for June is currently 60.2%, however, this is expected to increase as treatments are reported by month's end.

- The total number of patients over 62 days decreased in June to 291 and has further decreased to date, currently at 278 (July plan 225). Work is ongoing with Care Groups to reduce the number of patients over 62 days including clinical reviews of long waiters.

Responsive (Elective)
Cancer over 62 Day Breaches

62 Day Breaches (Target May: 250)
May Performance 352



High Level Performance Indicators

Cancer Standards	Standard	Final	Predicted
		May-23	Jun-23
31 day standard	96%	96.3%	96.2%
28 day faster diagnosis standard	75%	70.2%	71.9%
62 day standard	85%	62.7%	60.2%

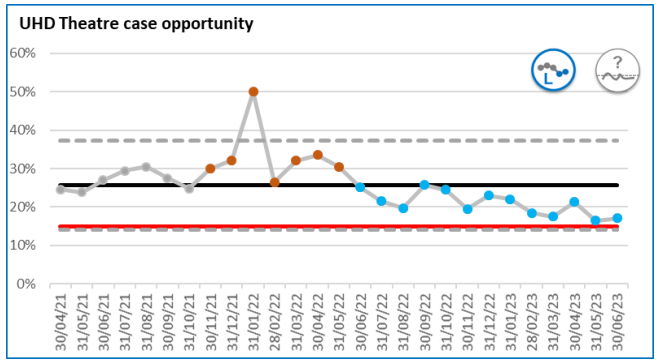
Key Areas of Focus

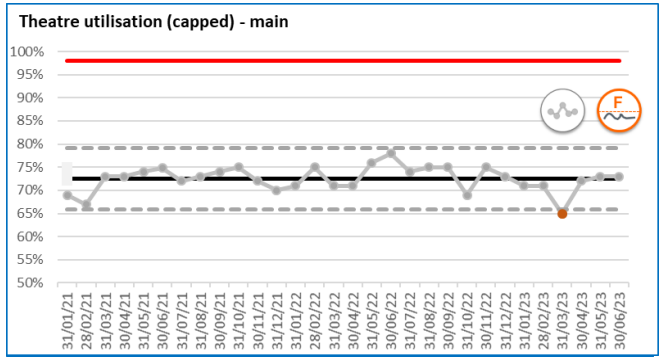
The priority areas for the next quarter continue to be Colorectal, Gynaecology and Urology.

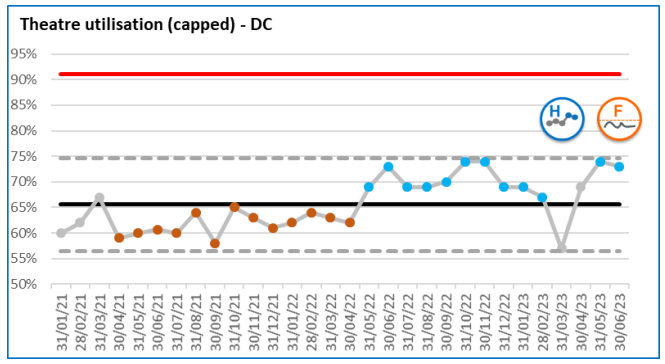
Key areas of focus include:

- Continuing to progress the development of a business case to move the Urology service to a nurse led diagnostic pathway planned to go live in Quarter 3, 2023/24.
- Delivery of additional Colposcopy clinics in Gynaecology, whilst the Gynaecology pathway transformation continues.
- Working with the Integrated Care System partners to ensure at least 80% of colorectal 2ww referrals are accompanied with a FIT test.
- Re-launch the Colorectal e-triage pilot to support the demand at the front end of the pathway.
- Delivery of waiting list initiatives for dermatology to increase OPA capacity (July to October 2023) and finalisation of the Tele-dermatology implementation proposals.
- Additional weekend clinics at Dorset County Hospital for breast patients.
- Promoting excellence in the basics including continuation of weekly clinical reviews of all long waiters to meet the over 62 Day trajectory for 220 patients by March 2024.
- Pathway mapping of the 2WW fast track bookings process and scoping of a digital solution using the Somerset Cancer Register to support efficient booking of patients at the beginning of their pathway.

Responsive (Elective)
Theatre Utilisation







Data Description and Target

Trust pursuing a **capped utilisation** of 85% which takes into consideration downtime between patients.
Intended utilisation is the utilisation booked into lists and excludes any on the day / 1-day prior cancellations. Theatre utilisation as reflected below includes emergency trauma lists which will be lower than capped utilisation (left) due to the unpredictable nature of emergency vs planned lists. Case opportunity is a measure of the time lost to inefficiency and expressed as the number of additional patients that could have been treated.

Performance

- A significant reduction in the case opportunity has been consistently delivered. Further improvement is required to achieve this target.
- June 2023 month end snapshot of intended (booked) utilisation is 87% but actual utilisation of 73.4%. The drop in actual vs intended (booked) is in part driven by the 72-hour strike action. Excluding Orthopaedic lists, which are impacted by equipment issues, booked utilisation increases by 5% and capped utilisation to 78.7%.
- The reduction in case opportunity has been sustained over a period of time.
- There is an upward trend for both number of lists run and number of cases in month in addition to the average cases per session.
- Lost minutes to early finishes has shown a steady decline from 50min at the end of April to current average of 33min with less variation.
- The time spent in theatre carrying out procedures is also showing improvement with an increase to touch-time minutes and a decrease in inter-case downtime.
- Average late starts have further decreased from 29mins to 25 mins with much less variability, demonstrating a more controlled process.
- Workforce pipeline is improving with trajectory showing a reduction of c 17WTE by Sept 23 (assumes no leavers).

Underlying issues:

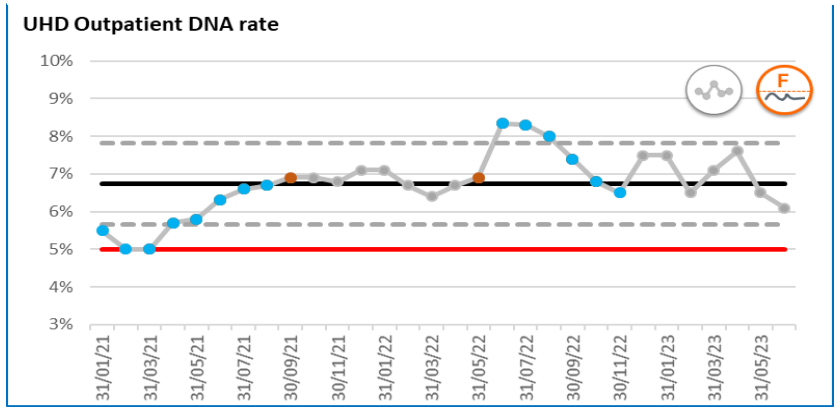
- Equipment issues including coordination of equipment has impacted orthopaedic late starts and an overall utilisation impact of c5%.
- Ongoing staffing shortages across theatres remains a significant barrier to providing a full template for all surgical specialities, noting improvement as above.
- Strike days are impacting across all theatre efficiency markers.

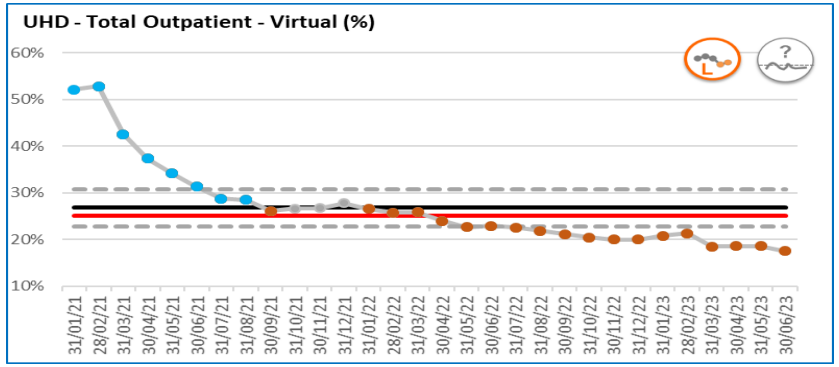
Key Areas of Focus

- Kit coordinator role progressed with interview scheduled w/c 10th July to support orthopaedic lists. Targeted work underway to focus on orthopaedic utilisation, including booking habits. This will increase number of patients being listed in addition to efficiency metrics.
- Ongoing improvement work focussing on theatre staffing is a top priority with workforce group in place and supported at Executive level. Improvement trajectories across all specialties to track progress.
- The implementation of the virtual pre-op assessment platform is also a key area of focus.

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	Last Year	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	33580	19634	-41.5%
Total Referrals Rate year on year		-0.5%	53522	29811	-44.3%
Outpatient metrics					
Overdue Follow Up Appointments (Cons-Led Only)					30594
New Attendances					20536
Follow-Up Attendances					30552
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%		3345 / 51088	6.1%
Hospital cancellation rate	*Hospital Canx / Total Booked Appts)*			11072 / 74089	14.9%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*			8584 / 74089	11.6%
Reduction in face to face attendances (acute only)					
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%		8933 / 51088	17.5%





Data Description and Target

- Reduction in DNA rate (first and follow up) to 5%
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

Performance

DNA rate in June improved to 6.1%, however remains consistently above target levels.

- Broadcast messaging via DrDoctor is being used to notify patients of cancelled appointments, fill fast-track slots and send appointment reminders to reduce DNA rates. The text reminder facility launched in May 2023 and is expected to demonstrate further improvement as it is extended.
- Outpatient appointment letters are also now available via the digital portal.

17.5% of attendances were delivered via telemedicine/video. This is consistently below the national target.

The number of patients overdue their target date for a follow up appointment reduced in June and demonstrates consistent month on month improvement. A pilot of using the 'quick question' functionality in DrDoctor to support validation of the follow up waiting list in Gynaecology was delivered in May and is now being extended to other services.

Continued industrial action at UHD has had an impact on outpatient booking teams' capacity and clinic capacity.

Key Areas of Focus

- Continued DrDoctor expansion to build on the soft launch undertaken of its 'Quick Question' and Broadcast messaging functionality within all services.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow ups and increased clinic utilisation rates.
- Embedding the outpatient performance dashboard (including all Outpatient KPIs) into performance management practices at Care Group and speciality level.
- Continuing to promote telemedicine/video and the benefits for patients.

Responsive - (Elective) Screening Programmes

Breast Screening

High Level Board Performance Indicators
JUNE position :

Breast Screening	Standard	ACHIEVED
Round Length within 36 months	90.00%	100%
Screening to first offered assessment appointment within 3 weeks	98.00%	93%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36

Background/target description
To ensure the breast screening access standards are met.
Performance:
- All but one of the KPI targets have been reached this month and round length is recorded as 100% for June.

Underlying issues:
- The screen to assessment target has been missed due to a delay in film reading as a result of the ongoing Radiology cover shortage. There is also pressure to cover the symptomatic service.
- Screening uptake is showing a steady increase with a return to timed booked appointments for recall women.

Actions:
- An IT assisted project is underway to enable a text messaging service which is planned to start this month.
- Our new Facebook page is also having a good reach across the region, and this will have a very positive impact on information sharing around the County.
- Health promotion is now a significant focus for the unit. A learning disability event was recently held which proved to be very successful. This will raise our profile and increase knowledge of our service to cohorts of our population that may have been under-represented previously.

Bowel Screening

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

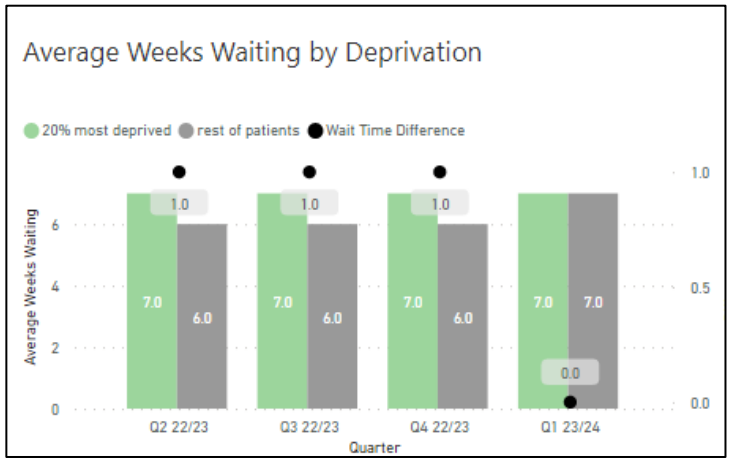
Background/target description
To ensure the bowel screening access standards are met.
Performance:
- SSP Clinic Wait Standard : The wait standard continues to be maintained at 100%.
- Diagnostic Wait Standard : The standard was achieved in June 2023.

Underlying issues:
- Lynch syndrome roll out has gone live for prospective patients and is rolling out later this month for retrospective patients.
- Next phase of age extension roll out is scheduled for August 2023. Delays in agreeing the finance plan with Commissioners have caused delays in recruitment for Specialist Screening Practitioners (SSPs).
- Senior doctor strike action will impact diagnostic list capacity in July 2023.

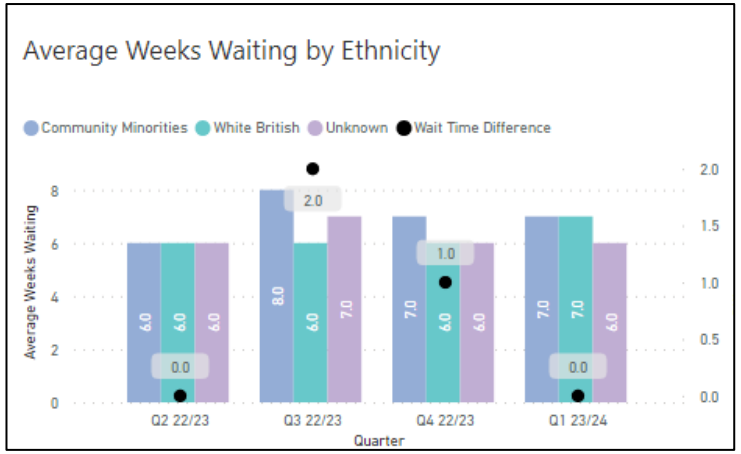
Actions:
- Plan for insourcing activity throughout 23/24 once finance plan finalised.
- Develop a succession plan for accredited screeners.

Health Inequalities

Median Weeks waiting by Deprivation Group



Median Weeks waiting by Ethnicity Group and Age



Average Weeks Waiting by Age

Age Band	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
0-9	6.0	11.0	12.0	11.0
10-19	7.0	8.0	10.0	9.0
20-29	7.0	7.0	7.0	6.0
30-39	7.0	7.0	6.0	7.0
40-49	6.0	7.0	6.0	6.0
50-59	6.0	6.0	6.0	7.0
60-69	6.0	6.0	6.0	7.0
70-79	6.0	6.0	6.0	6.0
80+	6.0	6.0	6.0	5.0

Data Description and Target

Analysis of variation in weeks waiting on an elective waiting list according to the patient's Index of Multiple Deprivation, age and ethnicity grouping to understand areas of variation.

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing RTT activity in Quarter 1 to date, the median weeks waiting at the point of treatment shows **no variation** between the 20% most deprived and the rest of the population treated. At sub-Trust level variation in waiting by deprivation is greatest in Elderly Medicine, Paediatrics, Cardiology, and Ophthalmology.

Waiting list by ethnicity: An analysis of the median weeks waiting by ethnicity grouping identifies **no variation** between patients within community minority groups and White British populations in Quarter 1 to date; this represents a change from the position reported last month when a variation of 1 week was noted. At sub-Trust level variation in waiting by ethnicity is greatest in Neurology and Elderly Medicine.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. However, this variation has reduced in Q1 to date. Paediatric waiting times in oral surgery, ENT and community paediatrics contribute to this variation.

Key Areas of Focus

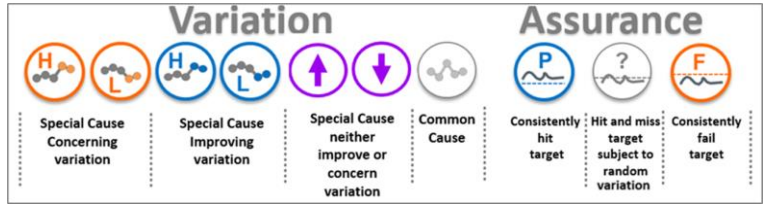
The Trust Health Inequalities group are working to:

- Deliver the Trust's strategic objectives for population health and system working; with a focus on ((i) reducing outpatient DNAs and variation according to IMD and ethnicity and (ii) managing High Intensity Users of emergency care.
- Align its health inequalities programme with the ICS key strategic priorities.
- Expand the data that's captured on the Dorset DiiS Population Health System to enable further data insights against the Core20Plus5 areas for adults and children.
- Promote awareness raising on health inequalities and population health through education and training opportunities.

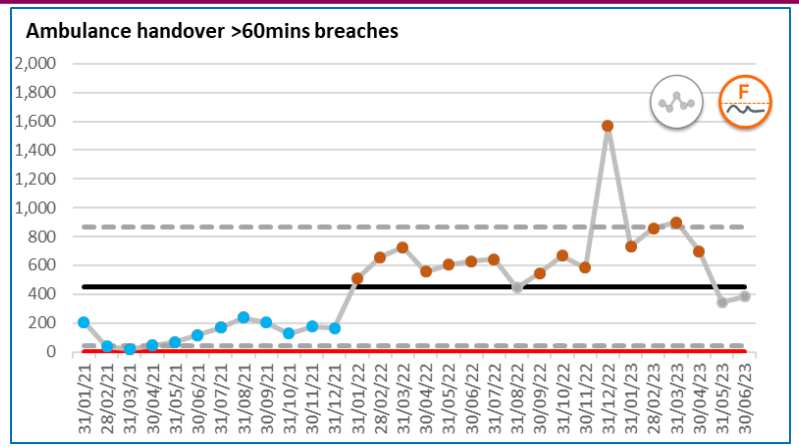
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Indicator

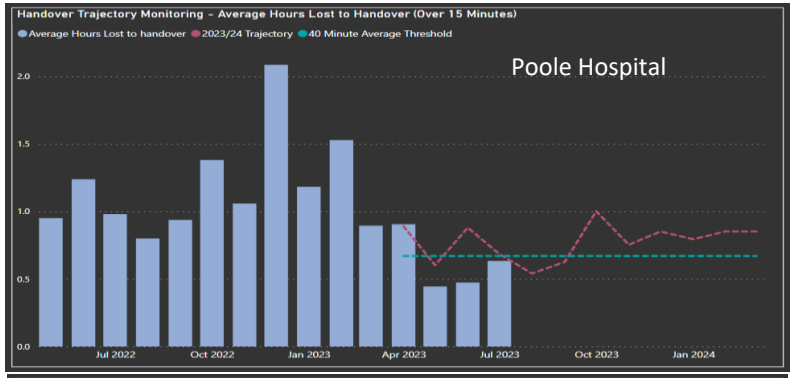
UHD Elective Care

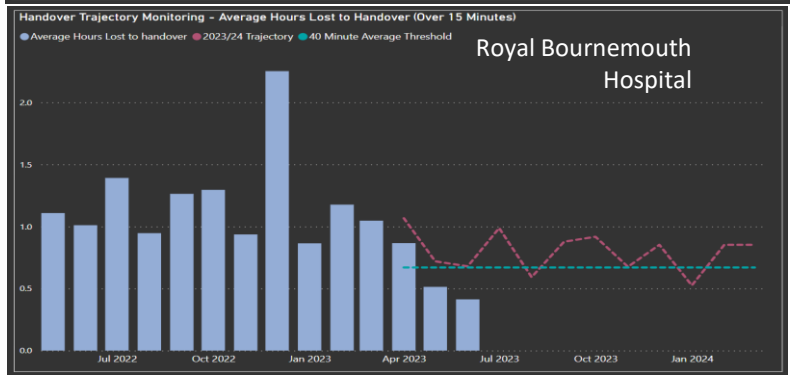
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Jun 23	74483	75073			73023	70356	75691
UHD - Patients waiting >104 weeks	Jun 23	0	0			107	32	182
UHD - Patients waiting >78 weeks	Jun 23	32	-			752	462	1042
UHD - Patients waiting >65 weeks	Jun 23	1053	1023			1687	1256	2118
UHD - Patients waiting >52 weeks	Jun 23	4574	-			3809	2966	4651
UHD - Patients waiting >52 weeks non admitted	Jun 23	3442	0			2219	1429	3009
UHD - RTT Performance against 18 week standard	Jun 23	55.1%	92.0%			59.1%	55.4%	62.7%
			0					
UHD - Total Diagnostic Waiting List	Jun 23	12584	-			10651	8776	12526
UHD - % waiting over 6 weeks	Jun 23	7.7%	1.0%			10.7%	4.6%	16.9%
			0					
UHD - Faster Diagnosis Standard (FDS) 28 days	May 23	70.2%	75.0%			70.3%	60.1%	80.6%
UHD 62 day standard	May 23	62.7%	85.0%			70.8%	62.2%	79.4%
			0					
Trauma Admissions	Jun 23	397	-			361	295	428
% of NOF patients operated on within 36 hrs of admission	Jun 23	37.0%	85.0%			29.6%	-14.6%	73.8%
			0					
UHD - Total Outpatient - Virtual (%)	Jun 23	17.5%	25.0%			26.8%	22.8%	30.7%
UHD Outpatient DNA rate	Jun 23	6.1%	5.0%			6.7%	5.7%	7.8%
Theatre utilisation (capped) - main	Jun 23	73.0%	98.0%			72.5%	65.9%	79.1%
Theatre utilisation (capped) - DC	Jun 23	73.0%	91.0%			65.6%	56.5%	74.6%
UHD Theatre case opportunity	Jun 23	17.1%	15.0%			25.7%	14.1%	37.3%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

Number of ambulance handover delays greater than 60 minutes from arrival to a receiving Emergency Department. 15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There should be no ambulances waiting over 60 minutes.

Number of ambulance hours lost due to handover delays. There is a site level recovery trajectory for lost ambulance hours per day.

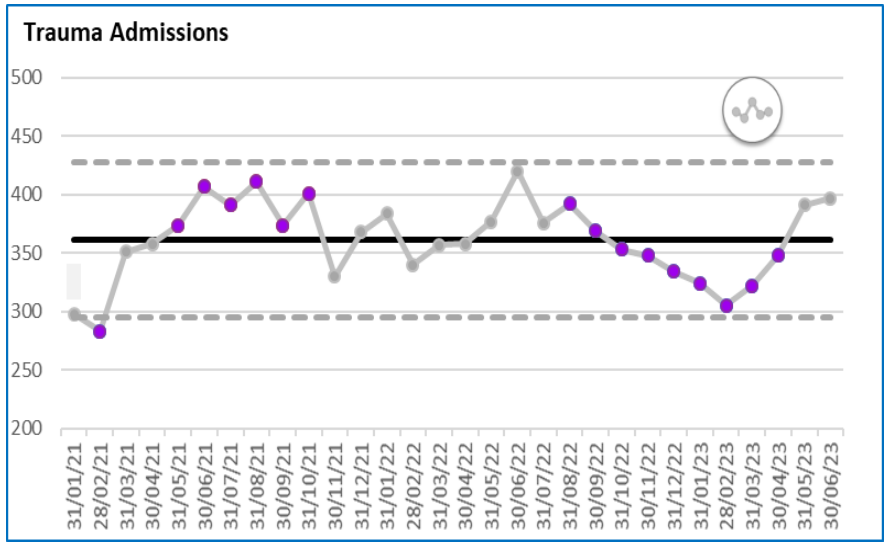
Performance

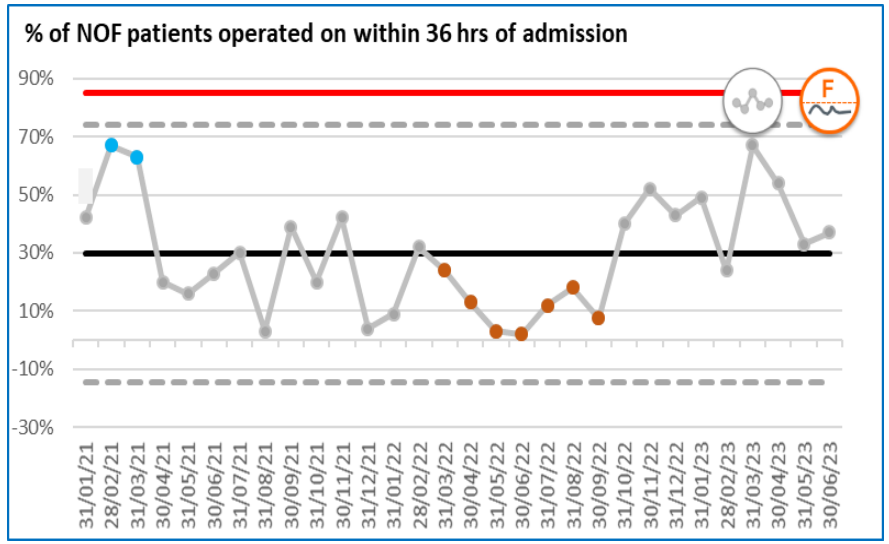
- Overall, a significantly improved picture for UHD with continued and sustained improvements.
- Ambulance arrivals remained static at the RBH site but saw an increase across Poole.
- 383 Ambulances waited over 60 mins in June, which marks a sustained significant decrease from 707 in April and 904 in March.
- In total there were 599 hours at PH and 540 hours at RBH totalling 1139 hours lost in June vs 1039 in May and 2284 hours reported as lost at UHD sites in April.
- Regionally however there was an improvement against handover delays with SWAST experiencing 18,180 lost hours vs 20,159 in May across the South-West.
- Discrepancy in lost hours reported continues to be a focus of improvement with regional partners via the SWASFT/ED working group along with Southwest wide task and finish group.

Key Areas of Focus

- Dorset ICB have re-established the joint meetings with UHD and SWAST to address the handover challenge, including a data cell.
- The SLA with ECS for corridor co-horting has formally ended as of June. Co-horting continues with SWAST and UHD staff for quality and safety purposes.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

NHFD Best Practice Tariff Target: Fractured neck of femur (NoF) patients to be operated on within 36 hours of admission. NHFD average 56%
Quality Target: 95% of fractured neck of femur (#NoF) patients to be operated on within 36 hours of admission and being clinically appropriate for surgery.

Performance

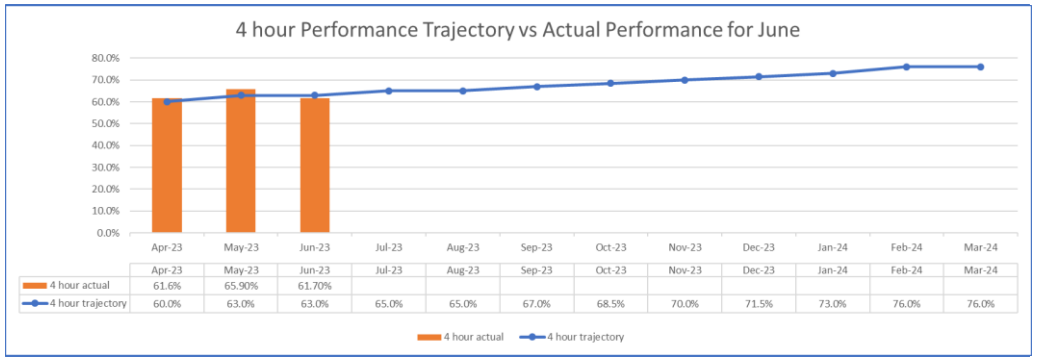
June performance for time to theatre for fractured neck of femur (# NoF) patients: 51% achieving surgery within 36 hours of being fit for surgery and 39% with surgery within 36 hours from admission.

- Large backlog (12) at the start of the month and high volume of referrals from fracture clinic causing challenge to time prioritisation.
- 165 Shaft of femur (SoF) fractures admitted in June, 14 had surgery, 9 required revision Total Hip Replacement (THR) for their fracture.
- 11 patients required 2 or more trips to theatre, resulting in an additional 17 trips to theatre, some of which were complex revisions and septic patients.
- The barn theatres are working well. Ongoing work to review case mix and paediatric capacity.

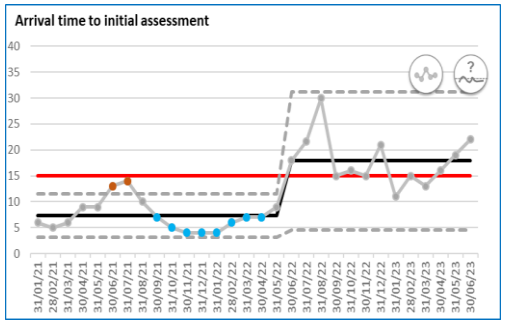
Key Areas of Focus

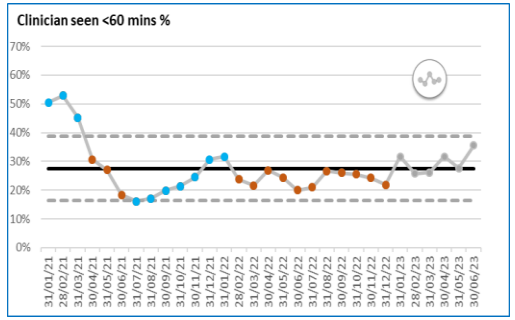
- e-Trauma , implementation and integration group commenced with dedicated T&O Lead in post; technical scoping complete.
- Trauma and Orthopaedic Ambulatory Care Unit (TOACU) - new location (old day theatres) complete. Review of activity to potentially relocate procedure room.
- Liaison with Trust operational flow project around timely admission and discharge (TAD) continues to support reduction in high level of MRFD patients across trauma (28%).
- #NOF summit areas of focus agreed to include pre-hospital "Pre alert" and #NOF admission pathway (mirror approach of stroke/cardiology). "Go live" 6th July.

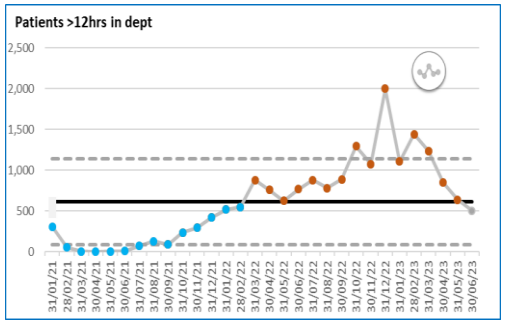
Responsive (Emergency) Care Standards

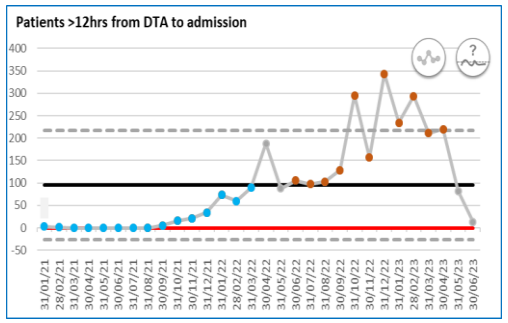


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	61.6%	65.90%	61.70%									
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	70.0%	71.5%	73.0%	76.0%	76.0%









Data Description and Target

UHD has now returned to reporting against the national 4-hour standard. The national requirement is to achieve 76% of all patients leaving ED within 4 hours of arrival by March 2024.

Performance

The Trust started reporting against the national 4 Hour Emergency Standard as of the 15th May. The Trust met its trajectory for both April and May 23, however June has proved to be a challenging month with the go-live of a new electronic PAS system 'Agyle.' This went live at the Poole site on the 13th June and at Bournemouth in July. Despite this period of instability, the department has managed to maintain its performance position at 61.7%, however it has been a contributory factor in being below target against the planned trajectory.

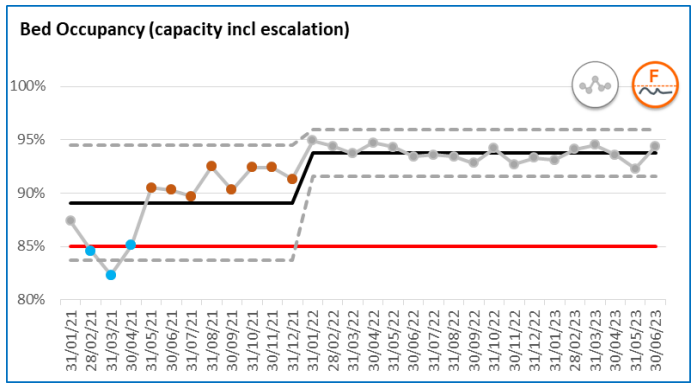
There has been a sustained improvement in reducing the number of patients spending more than 12 hours in both departments, which reduced by a further 133 patients in June. This was 504 vs 637 in May and 849 in April. There was also an improvement in the number of patients waiting for more than 12 hours after a decision to admit of 69 patients; 13 vs 82 in May and 220 in April, which is also the lowest in nearly two years marking a clear improvement in hospital flow.

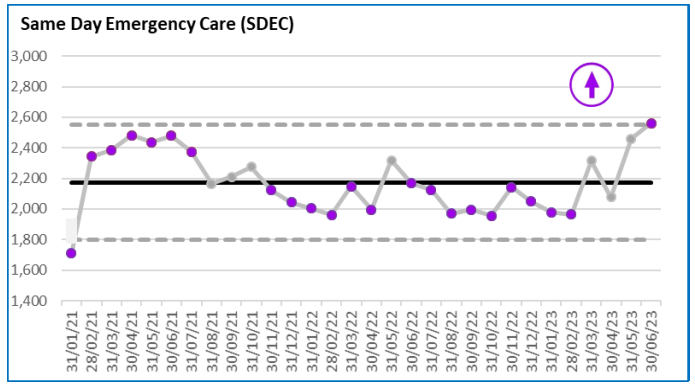
Key Areas of Focus

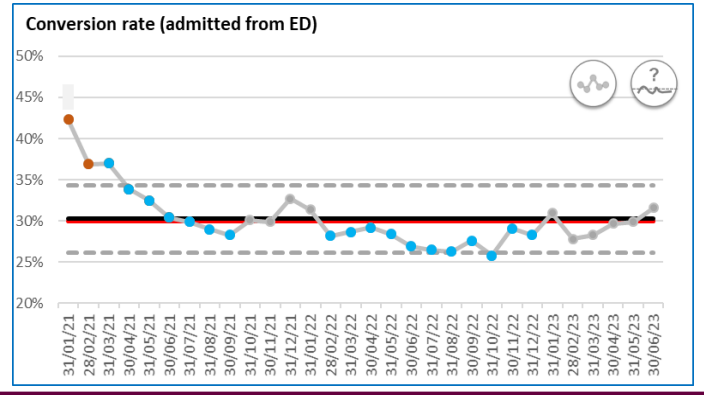
Full implementation of the new PAS (Agyle) system at the Poole site and embedding of the system at RBH following July roll out. Whilst there will be a period of bedding this in, ultimately the system will support more efficient patient management within the department as an enhanced clinical system, as well as a broader understanding of our breach analysis.

Continue on-going review of pathways out of ED with specific actions related to direct to admit pathways and onward flow following admission.

Responsive – (Emergency) Patient Flow







Data Description and Target

88% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed

Performance

Bed occupancy is stable but not reducing and continues to include high levels of escalation throughout June.

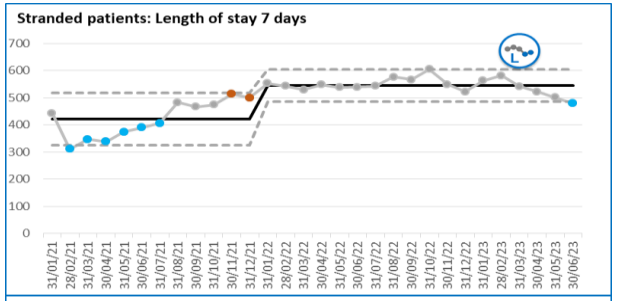
Additional capacity has been required to support the flow from ED, high occupancy, maintaining elective activity and emergency care demand.

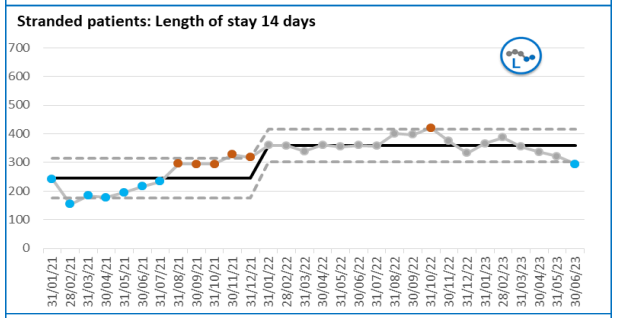
- High occupancy is driven by high numbers of patients with No Criteria to Reside although there has been sustained improvement in May and June.
- June saw an increase in ED conversion rate resulting in more patients admitted than discharged (net difference of 41 patients). There remained a consistent need to open surge capacity to manage high occupancy and MRFD levels.

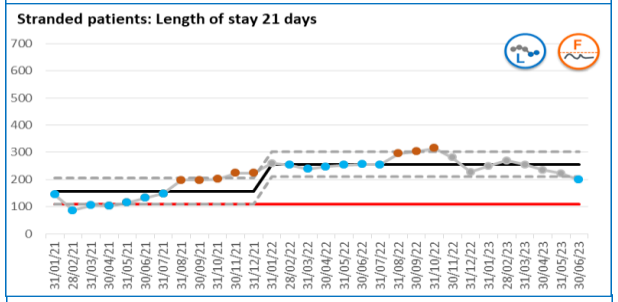
Key Areas of Focus

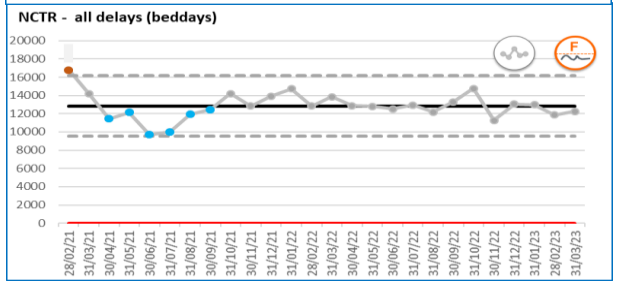
- Revised focus on Timely Admission and Discharge (TAD) process and significant improvement in utilisation rates of Departure Lounges.
- The Discharge to Assess model continues to embed, with System working in place to identify gaps in service provision and where flow through the out of hospital capacity has not achieved the required pace to prevent delays in hospital.
- Rapid review of daily bed management processes, including implementation of the centralised bed model trial in May and June 2023, with expected improvements in oversight, coordination and transfer time.

Responsive – (Emergency /Elective)
Length of Stay & Discharges









Data Description and Target

The number of patients with a length of stay greater than 7, 14 and 21 days.

The proportion of delays in discharge for whom the patient has no criteria to reside. Target to reduce the number of patients with No Criteria to Reside (NCtR) by 30% in Q1, and 50% Q2.

Performance

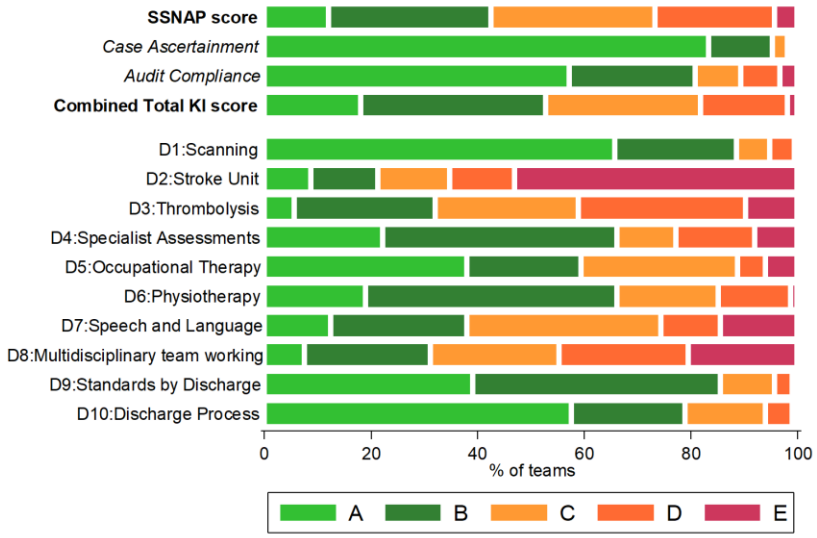
The average daily number of patients who are ready to leave/have no criteria to reside was 166 in June, 13 less than May which continues the downward trend.

- The ICB ambition to achieve a reduction of 30% in No Criteria to Reside was not achieved for Q1.
- The overall delayed discharge position continues to challenge hospital flow.
- The number of internal delays fell to 20%, work continues to improve internal processes with improvements seen in early June.
- The number of 21+ day patients shows improvement but at a slow rate, with increased focus through enhanced weekly reporting and review of patients in place.
- Delays in accessing community health and social care due to workforce and capacity remain factors impacting LoS

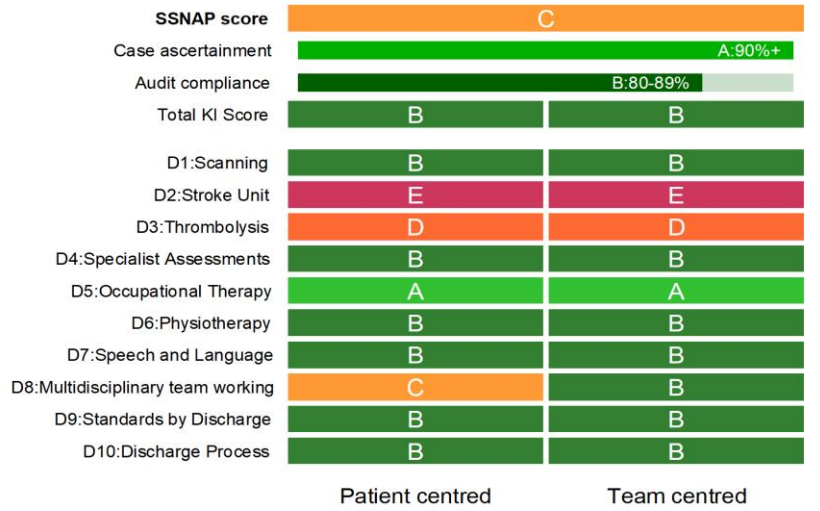
Key Areas of Focus

- Internal delays are reviewed and challenged daily, key themes include completion of therapy assessments and discharge referrals.
- Ongoing work with partners to broaden the D2A offer following learning from MADE events and patient reviews being taken forward through the regional Home First Steering Group and associated workstreams.
- Weekly high-level report being shared with all senior clinicians and Care Group Leads
- Daily partner meetings focusing on No Criteria to Reside, System working to redesign complex discharge pathways and Admission Avoidance strategy in ED and Assessment units
- System led Discharge to Assess (D2A) model implementation continues on all pathways, with some gaps for complex patients.
- Dorset System visits to UHD and Community Hospitals identified key system themes and opportunities for improvement. A weekly forum with the ICB and partners is in place to manage discharges for patients with an extended hospital stay.
- Via the Hospital Flow Programme Workstream 4, there is a focus on improving early discharge planning, ward MDT recording of Expected Date of Readiness (EDR) to leave hospital and D2A pathways in Health of the Ward (HotW).
- Development of electronic referral management for all MDT partners.

Responsive – (Emergency) Stroke



Source: SSNAP Jan to Mar 2023
Patient-centred results at national level



Source: SSNAP Jan to Mar 2023
Team level results

Team 560

Data Description and Target

To measure the quality of care provided to stroke patients (clinical audit) and the structure of stroke services (organisational audit).

Domain levels are combined into separate patient-centred and team-centred total key indicator scores. A combined total key indicator score is derived from the average of these two scores. This combined score is adjusted for case ascertainment and audit compliance.

Performance

- Q4 SSNAP C. Q1 data not yet available – date for data lockdown 8th August 23
- Reduction in MDT working 0.5 point off B
- Audit compliance 1.9 points off B
  - Mainly due to National Institute of Health Stroke Scale (NIHSS) on arrival and @ 24hrs
  - Over management of stroke mimics leading to reduced capacity in outreach team

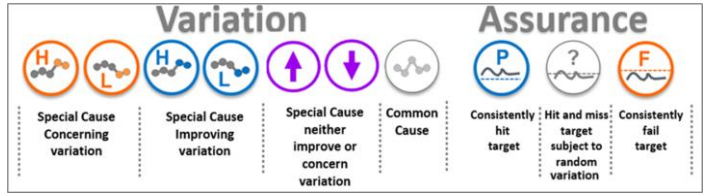
Key Areas of Focus

- Address audit compliance issues with team focusing on NIHSS scoring
- Align stroke pathways and processes across teams on Stroke Unit and Ward 9 stroke unit
- Data analysis for SDEC/TIA modelling completed, SBAR being developed. Space allocation to be agreed.
- Estates work for build on stroke unit delayed due to changes in funding
- 43 bedded workforce template to be finalised
- Development of Stroke ANP role to facilitate timely access including clerking and thrombolysis on the unit
- SQuIRE catalyst funding bid in progress to increase complexity in ESD service
- Potential bid being put forward through NHSI for pre-hospital video triage – in discussion with SWAST for agreement

Performance at a glance – (Emergency)
Key Performance Indicator Matrix

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	Jun 23	22	15			18	5	31
Clinician seen <60 mins %	Jun 23	36%	-			28%	16%	39%
Patients >12hrs from DTA to admission	Jun 23	13	0			95	-27	218
Patients >12hrs in dept	Jun 23	504	-			614	91	1136
4 hour safety standard	Jun 23	61.7%	76.0%			63.1%	51.8%	74.4%
Ambulance handovers	Jun 23	4015	-			3945	3448	4442
Ambulance handover >60mins breaches	Jun 23	383	0			454	44	864
			0					
Bed Occupancy (capacity incl escalation)	Jun 23	94%	85%			94%	92%	96%
Stranded patients: Length of stay 7 days	Jun 23	480	-			545	485	605
Stranded patients: Length of stay 14 days	Jun 23	294	-			360	303	417
Stranded patients: Length of stay 21 days	Jun 23	199	108			256	210	303
UHD NCTR % - all delays	Jun 23	38.5%	-			49.0%	41.4%	56.6%
			0					
Non-elective admissions	Jun 23	6347	-			5897	4959	6835
> 1 day non-elective admissions	Jun 23	3783	-			3721	3076	4365
Same Day Emergency Care (SDEC)	Jun 23	2560	-			2174	1797	2550
Conversion rate (admitted from ED)	Jun 23	31.6%	30.0%			30.3%	26.2%	34.3%
			0					
NCTR - all delays (beddays)	Mar 23	12250	0			12838	9531	16145
Ready to leave (beddays)	Mar 23	9356	0			7941	6366	9517
			0					



Sustainable Servicers

Pete Papworth
Chief Finance Officer

Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

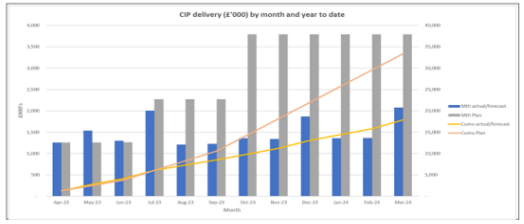
Committees:
Finance and Performance Committee

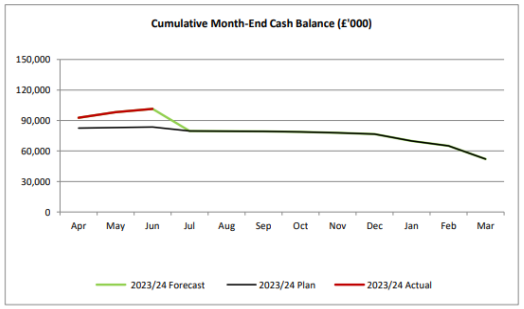
NHS
University Hospitals Dorset
NHS Foundation Trust

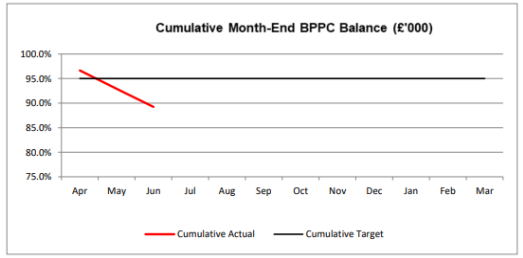
Finance

Executive Owner: Peter Papworth (CFO)

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(4,384)	(7,303)	(2,920)
Capital Programme	51,800	14,604	37,196
Closing Cash Balance	83,565	101,398	17,833
Public Sector Payment Policy	95.0%	89.2%	(5.8)%







Commentary

The Dorset ICS submitted a balanced revenue plan for the year, being the aggregate of individual organisational plans each of which confirmed a break-even revenue plan. However, the Trusts operational revenue budget for the year contains considerable financial risk. A range of mitigation plans have been identified and budgets continue to be actively managed to safeguard the financial performance of the Trust.

At the end of June 2023 the Trust has reported a deficit of £7.3 million against a planned deficit of £4.4 million representing an adverse variance of £2.9 million. This is mainly due to energy cost inflation £1.379 million, the net cost of the Nursing and Junior Doctors Strike £923,000, unfunded escalation costs of £839,000 together with premium cost pay overspends in the Care Groups. This has been off-set in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure.

Cost Improvement Programme savings of £4.1 million have been achieved as at 30 June against a target £3.8 million. This includes non recurrent savings of £2.5 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £17.9 million representing a shortfall of £15.5 million and a recurrent shortfall of £22 million. Mitigating this shortfall continues to be the key financial focus for the Trust.

The Trust has set a full year capital budget of £199.6 million, including £172.7 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme. At the end of June 2023 the Trust has committed capital expenditure of £14.6 million against a plan of £51.8 million representing an underspend of £37.2 million. This underspend relates mainly to the New Hospitals Programme and STP Wave 1. The STP Wave 1 full year forecast remains consistent with the plan, however the NHP forecast is dependent on timings of approval and may result in a lower year end spend requiring a re-phasing of the national funding.

As at 30 June 2023 the Trust is holding a consolidated cash balance of £101.4 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The balance attracts Government Banking Services interest of 4.89% at current rates, together with a PDC benefit of 3.5%.

In June there has been a deterioration in the Trusts payment performance due to volume of temporary staffing invoices experienced through the Temporary Staffing Office however recruitment within this team is in progress to further mitigate this risk. Finance continue to work closely in supporting the team in clearing invoices within 30 days.

Digital Dorset / Informatics

Peter Gill
Chief Information Officer

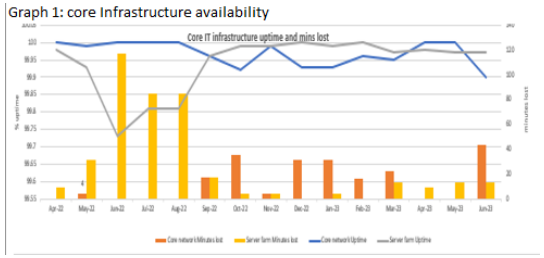
NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Informatics

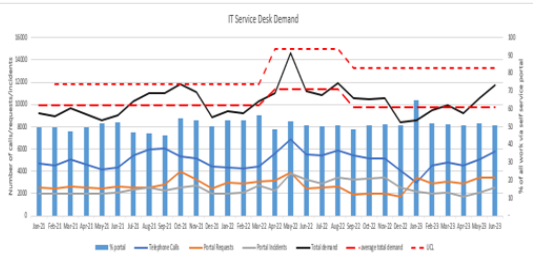
Executive Owner: Peter Gill (CIO)

Business as usual / Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



Projects / Developments / Security / IG

Table 3: Project Totals and Escalation

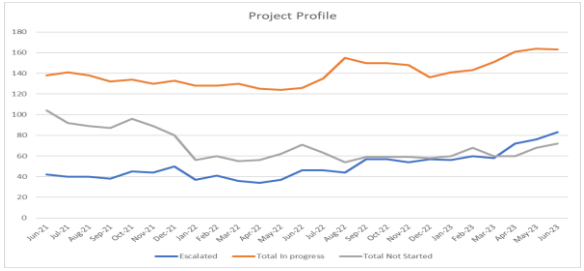


Table 4: Information Asset Compliance

All Active Assets

Status	Total	%
Draft Only (Pending Updates)	6	2.23%
Awaiting IAO Review/Approval	23	8.55%
Awaiting IG Review/Approval	60	22.30%
DSPT Compliant (2022/23)	180	66.91%
Total	269	

Table 5: Training Statistics

Total Trained in June: 682

Table 6: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	97.0%	3.0%	0.0%	3.0%
Windows Servers	88.2%	11.8%	0.0%	11.8%

Table 7: FOI compliance

	Total rec'd	Compliance
February '23	63	73%
March '23	60	70%
April '23	58	76%
May '23	57	70%

Commentary

Graph 1: The uptime remained above the expected level (99.9) even though there was some planned maintenance outages for server patching.

Graph 2: The Service Desk Demand remains within the bounds of common cause variation.

Table 3. The dominant work over June, was the implementation of the new Emergency Department IT system called Agyle from Fortrus. The cutover to this new system took place on 14 June at the Poole site with a plan to deploy to RBH on 10 July. The graph shows an increase in the number of escalated projects from 40 to 83 over the last 12 months. This is unsustainable and Informatics is engaging with the Patient First Process entitled Corporate Project Filter to address this. 12 projects were completed in June which were all new or updated electronic forms.

Table 4: Progress was made on the Information Asset Compliance work but at the point of submitting the national return only 67% of our high priority assets had the sufficient level of assurance.

Table 5 show the staff trained by system in June.

Table 6: 97% of our Windows desktop devices are now on supported operating systems and 88% of our server estate.