University Hospitals Dorset NHS Foundation Trust

Council of Governors Meeting

Thursday 29 April 2021

16:30 – 19:00

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 meeting of the University Hospitals Dorset NHS Foundation Trust Council of Governors will be held at **4.30pm** on **29 Thursday April 2021** via Microsoft Teams

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

Chairman

Time	Item		Method	Purpose	Lead
16:30	**1.**	Welcome, Introduction and Apologies for Absence	**Verbal**		**Chair**
	2.	Quorum	**Verbal**		**FR**
	3.	Declaration of Interests	**Verbal**		**Chair**
	4.	Minutes of the Meeting held on 28 January 2021	**Paper**	**Approval**	**Chair**
	5.	**QUALITY AND PERFORMANCE**			
	5.1	Integrated, Quality, Performance, Workforce and Finance Report	**Paper**	**Assurance**	**Chief Officers**
	5.2	Update on Covid	**Presentation**	**Assurance**	**CNO/ COO**
	6.	**GOVERNANCE**			
	6.1	The Appointment of the Lead Governor and Deputy Lead Governor	**Paper**	**Approval**	**Chair**
	6.2	Membership & Engagement Group Terms of Reference	**Paper**	**Approval**	**MEG Chair**
	6.3	Membership & Engagement Group Strategy	**Paper**	**Approval**	**MEG Chair**
	7.	Urgent Motions or Questions	**Verbal**		**Chair**
	8.	Any Other Business	**Verbal**		**Chair**
18:10	**9.**	**Date of next meeting: Thursday 29 July 2021 at 4.30pm via Microsoft Teams**			
		Note: A glossary of abbreviations that may be used in these papers will be found at the back of this document			
* Late paper					
		AGENDA – PART 2			
18:15	**10.**	**Chairman's Comments**	**Verbal**		**Chair**
	11.1	Minutes of the meeting held on 28 January 2021	**Paper**	**Approval**	**Chair**
	11.2	Minutes of the meeting held on 4 March 2021	**Paper**	**Approval**	**Chair**
	12.	**STRATEGY AND TRANSFORMATION**			

	12.1	Interim Annual Budget 2021/22	**Presentation**	**Discussion**	**CFO**
	12.2	Draft Sustainability Strategy	**Paper**	**Discussion**	**CSTO**
	12.3	Appraisal Paperwork for Non-Executive Directors	**Paper**	**Approval**	**CPO**
	12.4	Non-Executive Director Remuneration	**Paper**	**Approval**	**CPO**
	13.	Any Other Business	**Verbal**		**Chair**
	14.	Reflections on the Meeting	**Verbal**		**Chair**
	15.	**Date of next meeting: Thursday 29 July 2021 at approximately 6pm via Microsoft Teams**			
19:00	**16.**	**Close of Meeting**			

* Late Paper

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS PART 1 – PUBLIC MEETING

Minutes of the meeting of the Council of Governors held on Thursday 28 January 2021 at 16:30 hours via Microsoft Teams.

Present:	Mr David Moss	Chairman
	Ms Judith Adda	Bournemouth
	Ms Sue Parsons	Bournemouth
	Ms Diane Smelt	Bournemouth
	Ms Marjorie Houghton	Bournemouth
	Ms Sharon Collett	Bournemouth
	Mr Keith Mitchell	Bournemouth
	Dr Andrew McLeod	Poole and Rest of Dorset
	Ms Patricia Scott	Poole and Rest of Dorset
	Ms Christine Cooney	Poole and Rest of Dorset
	Ms Michele Whitehurst	Poole and Rest of Dorset
	Mr David Triplow	Poole and Rest of Dorset
	Mr Robert Bufton	Poole and Rest of Dorset
	Ms Sandra Wilson	Christchurch, East Dorset and Rest of England
	Dr Robin Sadler	Christchurch, East Dorset and Rest of England
	Mr Chris Archibold	Christchurch, East Dorset and Rest of England
	Mr Richard Allen	Christchurch, East Dorset and Rest of England
	Ms Carole Light	Christchurch, East Dorset and Rest of England
	Ms Marie Cleary	Staff Governor: Administration, Clerical and Management
	Mr Cameron Ingham	Staff Governor: Allied Health Professionals, Scientific and Technical
	Mr Markus Pettit	Staff Governor: Estate and Ancillary Services
	Ms Kani Trehorn	Staff Governor: Nursing and Midwifery
	Mr Conor Morton	Appointed Governor: Volunteers
	Prof Stephen Tee	Appointed Governor: Bournemouth University
	Mr Paul Hilliard	Appointed Governor: Bournemouth, Christchurch and Poole Council
	Dr David Richardson	Appointed Governor: NHS Dorset CCG
	Ms Beryl Ezzard	Appointed Governor: Dorset Council
In attendance:	Mrs Caroline Tapster	Non-Executive Director
	Mrs Debbie Fleming	Chief Executive
	Dr Alyson O'Donnell	Chief Medical Officer
	Mrs Paula Shobbrook	Chief Nursing Officer
	Mr Peter Gill	Chief Informatics and IT Officer
	Mr Peter Papworth	Chief Finance Officer
	Ms Karen Allman	Chief People Officer
	Mr Richard Renaut	Chief Strategy and Transformation Officer
	Mr Mark Mould	Chief Operating Officer
	Mr Alan Betts	Programme Director - Merger
	Mr Stephen Killen	Transformation Director
	Ms Zoe Jones	Corporate Governance Manager
	Mrs Carrie Stone	Company Secretary
	Mr Mike Weaver	Interim Assistant Company Secretary (minute taker)

CoG 001/21 Welcome and Apologies for Absence

Mr Moss welcomed everyone to the first Council of Governors meeting held in public in 2021. In particular Mr Moss welcomed members of the Council of Governors to the meeting who had much to offer the future development of the Trust. Mr Moss welcomed Ms Fiona Ritchie who would be joining the Trust as Company Secretary in March.

There were no apologies for absence.

CoG 002/21 Declaration of Interests

Mr Chris Archibold asked members of the Council to note he worked at a private eye hospital and therefore he may have to withdraw from the meeting when the meeting discussed use of the independent sector. Mrs Stone advised the Trust was working to complete the declarations of interest register after which it would be posted on the Trust website.

CoG 003/21 Patient Story

Mrs Shobbrook presented a video that outlined feedback received from the wife of a patient who was diagnosed with Alzheimer's Disease in January 2019, following his admission to Poole Hospital ED after a fall at home in November 2020 and the subsequent care he received both in the hospital and following his discharge, in the community.

Mrs Shobbrook noted the story had been discussed at the Board of Directors meeting held in public on 27 January. The story helped to frame the conversation at today's meeting and particularly matters that would be reported on the Integrated Performance Report later in the meeting. Mr Moss agreed it was a very moving statement that threw light on the difficulties that Covid-19 was causing for patients and relatives.

CoG 004/21 Chairman's Comments

Mr Moss welcomed members of the Council of Governors to the meeting.

CoG 005/21 Capital Programme for University Hospitals Dorset including an update on Transformation (to include Estates)

Mr Renaut and Mr Killen provided an update on the Capital Programme, including changes to the Trust Estate. The following key points were noted as follows:

- There would be three main site changes between February and October 2021.
- This included changes to the West (Eye Unit) Entrance and construction for the Maternity, Childrens', Emergency and Critical Care Centre at the Royal Bournemouth Hospital site.
- By August there would be a new Pharmacy accessed from the West Wing and Car Park B and a new West Entrance.
- From March 2021 onwards, Car Park A and, what was currently the consultants' car park, would be closed. Anyone arriving at the bus interchange would still be able to access the front of the site. Following the closure of Car Park A, people would be directed down to Car Parks B and C.

- A site compound would be created around the front of the Bournemouth site from October 2021 onwards. Access into the Emergency Department would be maintained at all times. Access into the Bournemouth site would be one way from bus interchange to the car park and then around and exiting the estate.
- During construction there would be additional spaces at Littledown to offset the loss of staff parking. Patients and visitors would be able to make greater use of the West Entrance and the Trust had recently approved some additional electric buggy pick up support. Work continued to reduce traffic onto the site that included community-based services, virtual clinics and staff working from home.
- New road access would open up at the back of the site. The Trust proposed to purchase land from BCP Council in order to construct a road linking the A338 Wessex way to RBH. This would be a left in / left out junction off the A338.

Mr Moss invited Governors to comment or raise questions in relation to the presentation.

Ms Ezzard welcomed the new capital investment. As the representative of Dorset Council Ms Ezzard welcomed the proposal for the new road coming off the A338 and asked to see more detail of the proposed road. Mr Renaut asked Governors to note that the proposed road had yet to receive planning permission. The road junction had been built and the proposed road would connect the back of the Bournemouth Hospital site to the road junction. As part of the Trust's land purchase BCP Council had committed to progress the road junction. The junction would help to ease traffic from the front of the hospital. The full fly over junction would cost circa £25m and was expected to be some years off. Mr Renaut noted that the hospital was effectively on a cul-de-sac and having this road in place would provide a second exit. There would be cycle ways and footpaths and so the Trust would be promoting sustainable transport as well. Mr Renaut asked Governors to note an area that had planning permission for an extension to the multistorey car park that would be directly accessed by staff and volunteers without having to drive through the whole site.

Ms Adda asked Mr Killen to clarify the meaning of figures reported in the Dorset HIP presentation. Mr Killen confirmed the figures were the allocation of funds from the Hospital Infrastructure Programme (HIP) for each site in the Dorset system.

Ms Wilson asked to know if the Trust was aware of any barriers that may prevent the Trust from meeting the target dates set out in its Capital Programme and if so, what were the contingency plans. Mr Renaut reported that the Trust had a comprehensive risk register with its contractors which had been shared with NHSE / NHSI. At a strategic level, the Trust believed it had overcome a significant amount of risk in relation to early funding and getting support for the Outline Business Case (OBC). The Trust had to submit its Full Business Case (FBC) at the end of March to the NHSE / NHSI team. The Trust was working on a Reserved Matters planning application with BCP Council in order to start work on site and any delay may create a risk to the Trust in terms of cost. There were also Covid-19 risks and other factors the Trust had allowed for.

Ms Whitehurst asked to know when the presentation would be updated to include detail of the Pathology Laboratory and multi-storey car park and how would the Trust keep patients and visitors informed of changes to the hospital site. Mr Renaut reported that Mr Moremon had developed a 12-month communications strategy that would be shared with Governors and staff.

With regards to the provision of car parking, the Trust would be putting information on the UHD website and operational teams would be updated on any changes made to car parking during work on hospital sites.

Ms Parsons asked to receive more information with regard to car parking arrangements at the Littledown Centre and asked if there would be parking spaces for Governors. Mr Renaut set out plans for parking at the Littledown Centre, noting that staff would mainly park at the Littledown Centre and this would then free up space for staff parking around the hospital to be made available to visitors and patients. Information would be included in appointment letters, on the Trust website, posters and signage. Mr Renaut explained that the Trust had not made a final decision on parking arrangements for Governors.

With regard to the proposed land purchase, Mr Allen asked for an update on the Trust plans for a science park. Mr Renaut reported there would be an update on this item later in the meeting.

Ms Trehorn asked to know if there had been any appeals against the proposed plans and if so, what measures had the Trust taken. Mr Renaut reported there was a Judicial review in response to the Clinical Services Review and that had now been fully completed. The Secretary of State referral had also been completed. In terms of planning permission, plans for Poole Hospital were fully supported by the planning committee and, as reported earlier, the Trust was working on a Reserved Matters planning application with BCP Council and that was expected to be fully completed in the next few days. The Trust had undertaken an extensive public engagement exercise since 2015.

Mr Bufton expressed concern over the delay to the proposed flyover to be built over the Cooper Dean roundabout and suggested there needed to be a risk assessment in order to understand the impact the delay would have on ambulance travel times to Bournemouth Hospital. Mr Renaut noted South West Ambulance NHS FT had undertaken a risk assessment as part of the Judicial Review and he would be happy to share the risk assessment with Mr Bufton.

Mr Pettit asked to know if the Trust was concerned that other users may use the road linking the A338 Wessex way to RBH and therefore clog up rear access to the hospital. Mr Renault confirmed access would be barrier controlled and only those with car parking permits would be allowed to use the road.

Ms Scott asked to know what procedures the Trust would have in place should the proposed work not be completed in time and, if there was a delay, would the Trust incur additional costs. Mr Killen set out contingency plans in place that included provision for inflation and any cost increases, noting the Trust had allowed for slippage. The original start date was 8 February, it was now 8 March, and this had been allowed for in the Trust's contingency arrangements.

Ms Houghton asked to receive a copy of the slides presented at today's meeting and noted the Trust was expecting to receive a larger amount of treasury funding than was originally planned and asked was that the case? Mr Moss confirmed Governors would receive a copy of the presentation and agreed the Trust was receiving a larger amount of HM Treasury funding for its capital programme.

The report was NOTED.

CoG 006/21 University Hospitals Status and ambitions

Mr Betts and Prof Tee introduced a presentation on University Hospitals Status and ambitions The following key points were noted as follows:

- The creation of University Hospital status was an important development that was built on the back of a long history of both Poole and Royal Bournemouth and Christchurch Hospitals working with Bournemouth University.
- Bournemouth University Centre for post grad medical research and education provided courses and events including an Annual Symposium accessed by the Trust's medical staff.
- Longstanding research and education links in nursing, midwifery and some allied health professional groups.
- UHD staff were visiting professors/associates, provided practice placements and access pre- and post-graduate training e.g. the Orthopaedic Research Unit.
- The partnership between UHD and Bournemouth University (BU) elevated existing arrangements to a whole new level. It allowed both organisations to work strategically to attract further investment and build the profile and reputation of both organisations for the benefit of the local community.
- There was a new Memorandum of Understanding that included a range of key deliverables. The Trust had appointed Prof John Vinney as an Associate Non-Executive Director to the Board of Directors. Dr Ruth Williamson Deputy Chief Medical Officer (UHD) had been appointed to the BU Senate, a key decision-making body and Mrs Shobbrook had been awarded a Nightingale Fellowship and Professorship.
- Prof Tee set out the priority areas for future partnership working between UHD and BU. This partnership would be a beacon for recruitment and retention of staff.

As the Allied Health Professionals, Scientific and Technical Governor, Mr Ingham noted he was excited by the research opportunities offered by Wessex Fields, but would like to reassure colleagues there would be access to sufficient resources e.g. MRI scanner to undertake research activity. Prof Tee confirmed the new Bournemouth Gateway Building on the Lansdowne Campus would include an MRI Scanner that would be used for research purposes. One of the advantages of attracting research income was the ability to do more research. Mr Betts confirmed the priority was to provide safe and sustainable services on the hospital site for patients.

Mr Allen welcomed the fantastic opportunities for research and innovation and asked if there would be opportunities for apprenticeships for people who did want to go down the academic route. Mrs Shobbrook reported on work to ensure there were opportunities to bring nurses into the pipeline of employment. Aside from the academic route there was the registered nurse degree apprenticeships and opportunities for staff to progress from working as health care support workers to go on to nurse training. There were also opportunities for allied health professionals and healthcare scientists.

Mr Triplow asked to know how Governors may get involved in future plans for the UHD and BU. It was noted that the Trust was keen to have Governor support and engagement and in particular the communities represented by Governors. The Trust had an ambitious plan for wider engagement that included events and open days. However, Covid-19 had had a substantial impact on those plans.

Ms Trehorn supported the plans and the opportunities set out in the presentation and asked if the Trust was not able to recruit a sufficient number of students locally would it consider national or international recruitment. Mrs Shobbrook confirmed the Trust had received funding from NHSE to help support recruitment. This was in addition to the other appointments for Healthcare Support Workers and Professional Registered Nurses. Prof Tee noted BU had recorded the largest intake of nursing students in its history in September 2020.

The report was NOTED.

CoG 007/21 Integrated, Quality, Performance, Workforce and Finance Report

Mr Mould presented a report on the operational performance of the Trust during December 2020. Key points were noted as follows:

- During December, the Trust started to see a surge in cases of Covid-19 but overall in December there was a further improvement in operational performance when compared to November and October. The Trust started to see more people in 18 weeks but it was recognised that during the month of December there was an increase in the length of time people were waiting.
- Diagnostics Waiting Times and Activity (DM01): the vast majority of people received their diagnostic treatment within 6 weeks across all diagnostic tests, which was extremely good.
- Urgent and Emergency Care remain busy. Whilst there was a reported fall in patients attending urgent and emergency care, all patients were required to be tested for Covid-19 on admission after which they were placed on to the appropriate care pathway. This resulted in delays at the front door and an increase in ambulance handover times.
- Cancer performance continued to recover. During the latter half of December the number of referrals started to reduce and it was thought this may be a result of the lockdown. Mr Mould asked Governors to note to encourage anyone with symptoms related to cancer to visit their GP. The Trust had the capacity to respond and provide an outpatient appointment.
- The total number of people waiting in the organisation for elective treatment had not changed when compared to the previous year. There were 45k people on the waiting list in January this year compared to 45k on the waiting list this time last year. However, as a consequence of Covid-19 there was a significant number of people who were now waiting over 40 weeks and over 52 weeks for their treatment and that was a concern locally, regionally and nationally and would form part of a bigger conversation about how the Trust recovered treatment.

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

- The Trust had not seen an increase in fundamentals of nursing care i.e. patient falls and pressure damage which were monitored very closely remained slightly lower than expected. This was an absolute testament to the work of all staff working on the wards.
- The number of patient moves, another quality indicator, had significantly increased out of hours. Whilst this was of concern, the number of moves reflected the need to maintain infection prevention and control measures.
- There were two national surveys running: the Inpatient Survey and the Urgent, Emergency Care Survey.
- The Trust had seen an increase in patient complaints related to communication e.g. answering phone calls as described in the patient story earlier in the meeting. In order to address these concerns the Trust was bringing volunteers on to the wards in order to support the clinical staff who were caring for the patients.

Dr O'Donnell also provided an update on the key performance indicators relating to quality, safety and patient experience. The following key points were highlighted:

- The Trust had successfully merged the learning from deaths and mortality surveillance groups across UHD.
- Mortality metrics were largely better than expected.
- There was very good collaborative work with some themed reviews being undertaken with teams from the historic organisations to look at how the Trust may bring the learning together.

Mr Gill provided an update on the Trust's Covid Vaccination programme. Key points were noted as follows:

- The Trust had now been able to offer the first dose of vaccine to all UHD staff and over the last week this had included associate staff e.g. domestic staff, students, apprentices and other front-line staff. It was estimated that up to 80% of staff offered the vaccine had accepted it and this was line with national levels.
- For the last week or so the Trust had been extending its vaccine programme outside of UHD.

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

- Ms Allman asked Governors to note the electronic rollout of the Trust's Virtual Learning Environment (VLE) the Green Brain at Poole Hospital.
- The Trust was working to recruit substantively and temporarily to fill immediate requirements. The Trust's Temporary staffing bank had been working extremely hard to bring staff into post.
- There was an increase in the levels of reported sickness and absence although this was starting to reduce.

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

- Consistent with the national interim financial framework, the Trust had set a deficit in the back half of the year of £5.6m. The Trust's position was very volatile given the operational challenges brought about by the pandemic.
- The Trust was currently in a favourable position circa £1m better than the plan year to date. However, the Trust was expecting the position to deteriorate in January given the pressures seen since the start of the new year.
- The Trust forecasts a year end position of circa £1.5m better than planned, although this should be treated with significant caution. The Trust was expecting two, year-end adjustments. One was the assumption that all non-NHS income would be recovered and that clearly would not be the case as the Trust was not charging for car parking and income from catering was down and there was very little private patient income. There would be a correction in March based on national modelling in order to give some additional funding to offset the loss of income. In March, the Trust would have to make a provision for untaken annual leave across the staff base and therefore that would be an additional cost.
- The pandemic had had a significant and material impact on the Trust's capital programme, in particular where the Trust had not been able to access clinical areas to undertake estates work. There had also been supply chain issues linked with the national lockdown. The Trust had slipped significantly on its capital programme and was trying to offset that by bringing forward significant amounts of medical equipment and IT from next year.

- The Trust had a significant cash balance at the moment although it was noted this included a significant payment in advance that would be corrected in March.
- The current financial arrangements were expected to roll over into at least quarter one of 2021/2022. The Trust was expecting to receive additional information in relation to the allocation in March. From quarter two the Trust expected to return to a more normal set of financing arrangements and would be expected to set a detailed operational plan during quarter one for July to March 2022.

Ms Collett thanked the Board for keeping Governors and other stakeholders informed about the priorities from the government and those arising from Dorset residents at the Board of Directors meeting yesterday. Ms Collet asked to know whether anything had changed in what had been an atypical phase in the way that the Trust reported on progress against targets connected with the national priorities. Mr Mould reported there was recognition nationally about having a lighter touch around the constitutional standards, noting that the Trust still needed to report on a weekly and monthly basis and was held to account on its performance e.g. the CCG asked the Trust to provide a formal response to matters in relation to ambulance handover times. The situation was expected to change once the effects of the pandemic started to ease. Mrs Shobbrook confirmed NHSE had been very supportive and the CQC had stepped back from their routine inspections and were taking a risk-based approach to inspection. The Trust maintained regular contact with the CQC.

Mr Allen expressed concern over the number of patients reported to be waiting for treatment, particularly those waiting over 40 weeks and above whose condition may deteriorate whilst they are waiting. Mr Allen asked to know if there was any hope that patients waiting over 40 and 52 weeks could receive treatment sooner. With regard to the reported rise in patient moves, Mr Allen noted patients and relatives were very concerned about the number of ward moves. Mr Mould asked Governors to note the number of patients waiting over 40 and 52 weeks was likely to continue increasing particularly as the Trust stepped down P3 and P4, lower priority treatments in the last three and four weeks and this expected to continue for another three weeks. Dr O'Donnell assured the Council of Governors there was clinical ownership of the waiting list and the Trust continued to actively surgically treat patients who had a high clinical priority. This was being coordinated through the Trust's Surgical Clinical Directors across UHD. Patients were prioritised appropriately no matter where they were initially booked for their care. Reactively, there was also a process in place to identify any patient who appeared to come to harm while they had been waiting. That would trigger a Serious Incident Investigation. Proactively the Trust was asking Consultants to look at patients who were becoming long waiters to ensure they did not have concerns that the patient's priority needed to be upgraded and that they need to be pulled forward in the priority list to be treated.

Mrs Shobbrook set out the reasons for the increase in patient moves. The Trust had totally changed its pathways in response to Covid-19 and it had happened very quickly in order to maintain infection prevention and control measures. With the increasing number of patients with Covid-19 in the community, the Trust had to quickly change its bed management processes which had resulted in an increase in patient moves. Mrs Shobbrook observed it was disappointing when relatives were not informed and that had happened on some occasions. The nursing team were concentrating on IPC measures and that is why the Trust was bringing in additional support to help the clinical teams. As rates in the community started to fall it was hoped the number of patient moves would also go down. The Trust had issued information to the public to explain the pressures the Trust is under in the hospital.

Ms Trehorn asked to know whether the Trust would continue to provide free car parking for staff. Mr Papworth confirmed the Trust had been providing free car parking since the start of the pandemic in April 2020. In the longer term the Trust would need to review the provision of free car parking as part of its overall strategy going forwards.

Mr Archibold asked to know whether there had been an increase in staff absence due to stress and what work had been done to alleviate stress for staff. In response Ms Allman reported the two highest reasons for staff absence during normal times were musculoskeletal injuries and stress. The level of stress related absence had gone up and there was a large programme of support offered to staff supported by information, advice and guidance on the Intranet. All staff and teams were being encouraged to access support to address their particular needs.

The Trust has a number of networks across the Trust that were working to support staff and understand what measures were working and what measures were not working. The Trust would continue to review the range of support it offered to staff. Ms Allman noted this was a long-term situation that would require continuing support for some time.

Dr McLeod noted the national 80% assumption for Covid-19 vaccination seemed very unambitious as you would expect people working in healthcare to be better informed. Dr O'Donnell understood the 80% assumption was based on national modelling and it was hoped that a higher percentage of UHD staff would accept the vaccine. There were a number of staff who could not be vaccinated because they had had a recent positive test and whilst this was not significant it did have an impact on the overall numbers. Dr O'Donnell reported that it was not possible to give exact figures at this time, but the Trust was confident it was achieving the national target and more.

The report was NOTED.

CoG 008/21 Update on Covid

Mrs Shobbrook introduced an update on Covid-19. Key points were noted as follows:

- Public Health Dorset and NHS England had provided very positive feedback about how UHD and the Dorset System were managing the pandemic.
- The Trust was absolutely focused on infection prevention and control that included providing education, training and an IPC toolkit for staff.
- The Trust maintained strategic oversight of what was happening in the organisation and the wider Dorset system. Mrs Shobbrook chaired the outbreak control meetings every day in her role as Director of Infection Prevention and Control (DIPC).
- The BCP 7-day case rate per 100k population from October 2020 was higher than the national England average. Public Health Dorset had provided epidemiological support to help understand what was happening in Dorset and how that applied to UHD.
- Mrs Shobbrook provided an update on the Trust's IPC approach that included action to implement IPC practice in line with national guidance and an established plan to manage blue and green pathways.
- In response to Mr Allen's earlier question, Mrs Shobbrook asked Governors to note that when patients come into hospital they are tested for Covid-19. The Trust then waits for the result of that test in order to ensure it was safe to move them through the hospital. This had an impact on patient flow.

Mr Mould presented an update on Covid-19. Key points were noted as follows:

- Mr Mould reported on work where the Trust had considered a number of scenarios around admissions and discharges across the organisation on a daily and weekly basis. This included work to understand what capacity the Trust needed to safely care for patients should there continue to be a rise in the number of Covid-19 patients.
- As a result of this work the Trust had made the difficult decision to slow down / pause some of its elective work in order to free up beds for Covid positive patients.
- The normal critical care capacity across Poole and Bournemouth Hospital would be 22 available critical care spaces. The Trust planned to surge up to 60 critical care spaces. All the work and experience from the first Covid surge in terms of equipping and skilling up staff and re-deploying them in critical care had been very beneficial in this current surge.
- The Trust had sought mutual aid as part of working with the Dorset ICS where each partner helped and supported each other around demand that was coming through the front door or the stepping down of patients in a safe and timely way.
- The Trust had worked very closely with the independent sector to maintain cancer operations where it was safe to do so.
- The Trust had worked with the Nightingale hospital in Exeter to safely transfer a very small number of patients which had allowed the Trust to free up bed capacity on a number of the Covid-19 positive wards.
- A number of military medics had also been working alongside Trust's teams across the organisation.

Ms Allman presented an update on Covid-19 in relation to support for staff. Key points were noted as follows:

- There was a wide range of enhanced wellbeing support available for staff that was constantly being updated.
- Staff were encouraged to work through the Trust's networks and managers in order to provide feedback on the support that was being offered.
- The Trust had implemented safe spaces, support and rest areas that included access to water and snacks. The Trust had utilised local and national charitable funds to support all the initiatives that were being offered.

Given the reported rates for Covid in the Poole and Bournemouth area last year were very low, Mr Allen asked to know why there had been such an increase in cases over the last month. Dr O'Donnell explained it was difficult to know precisely why there had been such an increase, noting there could be a number of reasons. The particular challenges had been in urban areas with a high population of youngsters. The new variant had led to an increase in transmission, particularly as it fed in from the South East. The national lockdown for wave one came at precisely the right time for Dorset. The short lockdown in wave two probably was not long enough. The social mixing over Christmas had most likely caused the surge of cases in January.

Having worked as a volunteer at a local vaccination hub and spoken to a number of people that have received the vaccine, Ms Wilson asked to know what the Trust was doing to advise people that even though they had received the first dose they must still abide by the Covid rules. Mr Moss agreed that everyone should follow the advice that had been given, even if they had received the vaccine. Dr O'Donnell confirmed that everyone receiving the vaccine were advised to be prudent and to follow the guidelines.

In terms of patient flow, Ms Whitehurst asked for comment and feedback on the process in place to ensure there was sufficient respect, dignity and support for the deceased and their family. Mrs Shobbrook noted this was clearly a very

distressing time for staff with the numbers of people that could be impacted, and the timeframes involved. It was also of course, a very distressing time tor families. The Trust had a visiting policy that included a caveat that allowed visitors for compassionate reasons. The care and dignity given to a patient at the end of their life was very important to the Trust and it was considered one of the fundamentals of care. Mrs Shobbrook assured the Council of Governors there was a process in place that formed part of the Trust's Major Incident Planning response.

Mr Moss expressed his thanks to all members of the executive team who had attended and contributed to the meeting today. It has been a very useful session and it would be repeated at a future meeting.

The report was NOTED.

Dr O'Donnell, Mrs Shobbrook, Mr Gill, Mr Papworth, Ms Allman, Mr Renaut, Mr Mould, Mr Betts and Mr Killen left the meeting.

CoG 009/21 Terms of Reference: Nominations, Remuneration and Evaluation Committee (NREC)

Mrs Stone presented the proposed Terms of Reference of the Nominations, Remuneration and Evaluation Committee (NREC) for the Council of Governors of University Hospitals Dorset NHS Foundation Trust. Key points were noted as follows:

- This was the one Committee of the Council of Governors that had constitutional status. Annexe 5 of the Trust Constitution, Standing Orders for the Practices and Procedures of the Council of Governors.
- Mrs Stone and Mr Moss had considered the tenure, membership and quoracy for the committee and this was reflected in the terms of reference of and the content of the Trust's approved Constitution.
- Members of the Council of Governors were asked to comment on and consider for approval the Terms of Reference. Should they be approved they would be added to the Trust's website.
- Approval of the Terms of Reference would enable the Trust to seek nominations from Governors who may submit expressions of interest. There were three cohorts of Governors that made up the membership in order to reflect the different elements and aspects of the Council of Governors.
- Membership would include three members from the publically elected constituency, one nominated member from appointed governors and one member from the staff constituency. Publically elected governors had a majority.
- On Monday 1 February expressions of interest would be sought from all Governors with a view to seeking nominations. Should there be a competition, there would be a ballot and in the event of a tie, Mr Moss as chair of the Council of Governors would have the casting vote. It was hoped the process would be completed within the next two to three weeks. The first meeting of NREC would take place on 4 March to consider making a recommendation to the full Council of Governors regarding the appointment of the Chairman, the Non-Executive Directors and the Chief Executive.

Mr Bufton reported he had not received a copy of the Terms of Reference and therefore he would not be in a position to approve them. Mrs Stone confirmed the Terms of Reference had been circulated in the pack of meeting papers. Mr Bufton was advised to check the electronic link to the papers in the meeting invite.

Mr Triplow noted the Lead Governor was automatically a member of the RBCH NHS FT NREC. The Lead Governor had the most dealings with the Chair, is part of the appraisal process and helped to manage any matters concerning other Governors. Not having a Lead Governor on NREC would be a mistake and make the task of the Lead Governor more difficult. Mrs Stone explained the rationale for the proposed membership of the UHD NREC. This was an iterative process and it was for all Governors to take a view on what was recommended.

With respect, Mr Allen took issue with the Chairman having a casting vote as they would be voting for someone who would be responsible, for evaluating their performance. Mrs Stone clarified the point that the Chairman would have a casting vote should there be a tie for Governors nominated to become members of the Committee, not as part of the normal duties and operation of the Committee.

The company secretariat agreed to send Mr Bufton a copy of the NREC Terms of reference.

Ms Ezzard asked to be informed of the ratios pertaining to the different constituencies on the Council of Governors. Mrs Stone explained the composition of the Council of Governors included appointed Governors, staff Governors and public Governors who represented three public constituencies.

The Council of Governors APPROVED the Terms of Reference of the Nominations, Remuneration and Evaluation Committee (NREC).

CoG 010/21 Proposed Process for the Appointment of a Lead Governor

Mrs Stone presented the proposed process for the appointment of a Lead Governor. Key points were noted as follows:

- Mrs Stone thanked Mr Moss for his support in developing the proposed process which had taken into account guidance from other organisations and advice from a number of company secretaries.
- The Trust's Constitution (Annex 4) stated 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.
- It was the view of Mr Moss and Mr Stone that all Governors should have time to experience and understand the workings of the Council of Governors before the process of appointing a Lead Governor and Deputy Lead Governor was started. Subject to agreement of the process today it was proposed the process to appoint a Lead Governor and Deputy Lead Governor would commence in the first week in April 2021.
- The Council of Governors was asked to comment on and approve the proposed process for the appointment of a Lead Governor so that the Company Secretary could organise the appropriate action.
- If any Governor was interested in nominating themselves to stand as Lead Governor or Deputy Lead Governor they were very welcome to contact Mr Moss or Mrs Stone. The appointment of the Lead Governor and Deputy Lead Governor would go to the Council of Governors' meeting at the end of April for approval.

Mr Archibold asked whether it would make sense for the Deputy Lead Governor to take over from the Lead Governor when their term of office came to an end and therefore enable a seamless transition. In the vote, instead of running two elections, would it make sense for the candidate who received the most votes to be elected as Lead Governor and the candidate who received the second largest number of votes to be elected as Deputy Lead Governor. Mr Archibold asked the Trust to circulate a brief outline of the time commitment and what was required of the Lead and Deputy Lead Governor to all members of the Council of

Governors.

Mrs Stone noted there was an outline job description that set out what the role involved. This may change if the Lead Governor joins NREC. The point regarding the Deputy Lead Governor succeeding the Lead Governor was noted. In section 3 of the proposed process the Trust would be adopting a first past the post approach. Mrs Stone asked all Governors to consider whether it would be reasonable to agree the first past the post was appointed as Lead Governor and the second past the post was appointed as Deputy Lead Governor. Members of the Council of Governors supported the proposed amendment to the process and Mrs Stone agreed to amend this accordingly. Mrs Stone noted the initial tenure of the Lead and Deputy Lead Governor was one year. The Council of Governors may wish to agree a longer tenure.
The Council of Governors APPROVED the proposed process for the appointment of a Lead Governor subject to the amendment that the first past the post was appointed as Lead Governor and the second past the post was appointed as Deputy Lead Governor.

CoG 011/21 Board Policy for Engagement with the Council of Governors

Mrs Stone presented the proposed Policy for Engagement with the Council of Governors. Key points were noted as follows:

- The Board approved the Board Policy for Engagement with the Council of Governors and recommended it for information to the Council of Governors at its meeting in Public on 27 January.
- The Policy fulfilled the requirement of Monitor's Code of Governance (provision A.5.6) and reflected Annex 6, Section 6: Governors and Directors: Communication and Conflict of the Trust's Constitution, that was previously approved.
- It is important from the public's perspective that they could very clearly identify code and constitutional requirements. This document would be published on the Trust's website.

Mr Moss noted the whole basis of engagement was about building relationships and partnerships and trust.

The Council of Governors NOTED for information the Policy for Engagement with the Council of Governors.

CoG 012/21 Motions on Notice

None received.

CoG 013/21 Urgent Motions or Questions

None received.

CoG 015/21 Any Other Business

As noted in the informal meeting there was a strong view that the Trust should send a letter of gratitude to all staff. There was also a request that the Trust should send a communication to volunteers as well.

Ms Collett proposed that a vote of thanks and acknowledgement of work should include Executive and Non-Executive Directors in recognition of the work they had been undertaking and the responsibility that they held. Mr Moss noted that Executive Directors had been working under considerable pressure and working extraordinary hours and it would be appropriate for the Council of Governor to

express a note of thanks.

CoG 016/21 Date of next meeting

Thursday 29 April 2021 at 4.30pm via Microsoft Teams

Agreed as a correct record of the meeting:

*Chairman*_____ *Date* _____

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 29th April 2021

Agenda item: 5.1

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

Prepared by:	Executive Directors, Donna Parker, Jacqueline Coles, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Louise Hamilton-Welsh, Jo Sims, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Council of Governors on the performance of the Trust during March 2021 and consider the content of recovery plans
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. All NHS organisations have now received the '2021/22 priorities and operational planning guidance outlining the priorities for the year ahead'. It sets out the context that "*we do not yet know what the pattern of Covid-19 transmission will look like over the next 12 months and it is clear that the impact of the last year will be felt throughout 2021/22 and beyond*". **Key priorities for 2021/22:** A. Supporting the health and wellbeing of staff and taking action on recruitment and retention B. Delivering the NHS Covid vaccination programme and continuing to meet the needs of patients with Covid-19 C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay F. Working collaboratively across systems to deliver on these priorities. We are working together with the Dorset system to produce our organisational and system operational plans that aim to address these

	priorities and the performance related requirements set out.
Key points for Board members:	**Areas of Board Focus** 1. Attendances to ED and emergency admissions for non-Covid reasons started to return to pre-Covid levels during March enough bed capacity for those that need to be admitted is key without impacting on our elective recovery. 2. Focus has remained on urgent and cancer care during March with elective routine activity recommencing in specialties where it was safe to do so. Plans are in place to address the growing number of patients on routine waiting lists and in particular the high number of 5595 patients waiting over 52 weeks for treatment. Recovery to pre-Covid levels will require investment and take some time to deliver due to workforce and capacity limitations, there could be an impact on hospital reputation in the South West region as Dorset was hit harder during response to wave 3 of Covid than other systems. 3. Whilst some improvement was seen during March, the current number of patients who are medically ready to leave and not meeting Criteria to reside remains and this puts additional pressure on workforce to staff escalated bed capacity, driving increased costs and has a potential impact on quality including elective care recovery. **<u>Operational Performance</u>** **Emergency Care** ***Emergency Departments*** The IPR provides the detailed performance against the key Emergency Care standards. Overall the improving picture seen later in February has been maintained through March. Headlines include: • Attendances and admissions returning towards pre Covid levels in March (c3000 more ED attendances) • Improvement seen in mean times within both departments (marginally above 200 min indicative standard) • No 12 hour waits from Decision to Admit (DTA) • 60 min ambulance handover breaches reduced to 20 (36 previous month, 203 in January) • Slight increase in 30 min handover breaches, but overall improvement in average handover duration was maintained. Changes on the previous month (below) do support the need for our continued work on improvement actions with time to clinician assessment being a particular area of focus. This work is supported by new 'real time' and look back dashboards which support escalation actions as well as benchmarking and shared learning. *(colours based on change from last month)*

		Mar-21		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	205	206	205
Time to assessment	15 mins	3	8	6
Internal Care Standards				
Time to triage (*RBCH: to assessment*)	15 mins	3	8	6
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	61	90	77
Time waited for a bed (*RBCH: DTA to left dept*)	60 mins	143	62	96

Occupancy, Flow and Discharge

Our internal work on 'Criteria to Reside' together with the system-wide Home First programme continue. **Detail on the key streams of work, actions and progress are included within the IPR, including the Escalation Report**. Key headlines relating to occupancy, flow and discharge include:

- Admissions vs discharges remained in balance
- Bed days occupied by patients >7 and >21 days continued to improve, as did overall occupancy
- Pre Easter saw a reduction in patients with 'No Reason to Reside (NRTR)
- Our internal Criteria to Reside (C2R) programme has progressed well, with a significant improvement in data completeness on the phase 1 wards
- Reshaping of the Home First programme delivery groups is complete and workstreams being supported by the ECIST and John Bolton work and a system wide 100 day plan
- Internal bed capacity modelling work is well progressed and we are working on mitigation plans for any potential demand and capacity gaps.

Note : Board workshop agreed for the end of April on 'No Reason to Reside' (NRTR)

Surge, Escalation and Operational Planning

We are now seeing a very low number of Covid patients in the community and presenting to the hospitals. However, pathways and testing in line with IPC guidance is being maintained. Following learning from the last wave, we are reviewing our plans and how we would support capacity and pathways for up to 5% of Covid inpatients with minimal impact on the rest of the hospital.

We continue to maintain an 'incident response' mechanism to support the current level of NHS incident and response to any surge or latest guidance. The Dorset system is currently reviewing the system structure going forward to maintain reliance, operational and strategic planning and implementation. This will also be supported by our internal and system operational planning in response to the 2021/22 priorities and operational planning guidance.

Improvements in emergency care as highlighted above has placed us in a better position in terms of Regional benchmarking and this quality and performance improvement work, alongside our ongoing operational and financial planning will be key to reaching a sustained position. Furthermore, escalation policies developed to support the above also contribute to maintaining safe and responsive care within our departments.

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

	Mar 19	Feb 21	Mar 21	
Waiting List Size	42,587	45524	47133	**+4546 v March 19**
Referral to treatment 18 week performance		59.3%	**58.2%**	**-1.1% v Feb 21**
RTT incomplete pathways >52+ weeks		5325	5595	**+270 v Feb 21**

Providers and commissioners are required to plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2021 than in March 2019. At the end of March '21 there were 47,133 patients on the waiting list, 10.7% more than the combined March 2019 position of 42,587, this is a worsened position from February 2021.

The overall waiting list is still at a higher level than last year with a corresponding increase in backlog of patients waiting over 18 weeks, this has resulted in a slight reduction in performance from 59.3% to 58.2%. Whilst the number of patients waiting over 40 weeks has reduced slightly, there has been a rise in patients waiting over 52 and 78 weeks.

There are 5,595 patients waiting over 52 weeks, an increase of 270 patients from last month, this is higher than the trajectory submitted to the South West region which was 4486 for March 2021.

Factors impacting on the RTT standard

Clinical Capacity & Response to COVID-19	The reduction in RTT performance and rising number of patients waiting > 52 weeks is a cumulative problem due to ceasing routine elective activity in Q1, restoring routine activity within new Infection Control guidance during Q2 & Q3 followed by the need to pause routine elective activity during the Q4. The waiting list has risen slightly due to the transfer of the routine elective waiting list from Dorset Healthcare University NHS FT to UHD, this is part of the Dorset ICS recovery plan and in line with national recommendations to have a single system waiting list. Clinical staff have been redeployed from theatres, endoscopy, outpatient services and other areas to support the wards and critical care in the Trust response to COVID-19, this has resulted in lost clinical capacity to run routine elective services. Many patients are choosing not to attend hospital for consultation, diagnostic test or treatment until they have had their vaccination and/or the pandemic is over. In recovering routine elective activity, specialties productivity will remain lower than previous years due to

	restoring services safely in line with national and clinical infection control guidance which make each outpatient attendance, diagnostic test and procedure / treatment take much longer. There is regional recognition of the challenging position of elective care performance in Dorset prior to COVID-19 and this has resulted in many patient waiting > 52 weeks for treatment. The growing number of 52 weeks is mainly due to lack of theatre / treatment capacity however due to lost capacity during Q1 and Q4, there are now patients waiting over 52 weeks for an outpatient appointment. The waiting list for patients waiting to be admitted for treatment is clinically reviewed and prioritised to reduce any potential harm for those patients waiting longer than expected for their procedure.

High level elective care recovery actions include:

- Clinically led Validation Programme of all waiting lists commences in April 21, this programme of work is aimed at clinically prioritising patients and ensuring that they still require to be seen or have treatment. It is expected that there will be considerable attrition from the wait list allowing clinicians to allocate capacity to see the patients who still need care or treatment
- Creating additional capacity to see and treat our longest waiting patients, this includes use of the independent sector, using other NHS and private providers, insourcing using a partner organisation and running wait list initiatives where possible
- Think Big is a project to enable high volumes of outpatients to be seen safely
- Use of digital technology to support non face to face outpatient activity.

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

March	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	7313	7104	209	**2.9%**

The DM01 standard has achieved 97.1% of all patients being seen within 6 weeks of referral, 2.9% of diagnostic patients have waited > 6 weeks. Radiology have achieved > 99% of all patients being seen < 6 weeks from referral. Endoscopy and all other diagnostic services continue to improve with an ambition to achieve in Q1 of 2021-22. This is a remarkable achievement and testament to all the previously reported plans delivering during Q3 and continued in Q4.

This is a good position to be in at the end of March, noting endoscopy activity has been considerably reduced as the service has deployed staff to wards and critical care whilst keeping urgent endoscopy services open.

High level diagnostic recovery actions include:

- Continuation of additional temporary endoscopy capacity on the RBH

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

Cancer Standards

Measure	Target	Quarter 1 2020/21	Q2 20/21 FINAL	Q3 2020/21 - FINAL	Jan 21 - FINAL	Feb 21 - FINAL	March 2021 - Predicted
Cancer Two Week Wait	93%	96.7%	97.3%	N/A	N/A	N/A	N/A
Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	80.0%	78.6%	78.5%	71.6%	80.0%
62 Day Screening Standard (Tumour)	90%	73.3%	73.3%	94.1%	86.7%	83.8%	94.7%
31 Day First Treatment (Tumour)	96%	96.2%	94.4%	97.0%	96.6%	94.5%	97.8%
Subsequent Treatment - Surgery	94%	89.4%	86.7%	95.4%	83.9%	92.0%	92.1%
Subsequent Treatment - Radiotherapy	94%	98.8%	100.0%	98.7%	100.0%	98.2%	100.0%
Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%
Faster Diagnosis	75%	76.3%	77.4%	80.7%	72.5%	80.2%	82.9%
Over 104 days (treated in month)	N/A	18	23.5	26	5	7	9

Whilst the rate of 2 week wait referrals altered considerably month on month during the last year in total the Trust received 27712 (4 less than last year). However certain tumour sites have experienced unprecedented increases (compared to the previous year, namely breast 11%, gynaecology 7% and head and neck 20%.

In terms of overall performance - whilst the Trust does not have to externally report against the 2 week standard it is expected this will be achieved in March.

Unfortunately, the reported position for February still fell short of National KPI's for the key standards - however the position has improved considerably for March – final reported position due on 5/05. This position is reflected Nationally, with the National 62 day performance sitting at 70.6%.

Overall the backlog and backstop position continues to steadily improve, (of the total PTL now 2.86% and 1.33% respectively). Some tumour sites are still challenged which obviously effects the Trusts overall position

Factors impacting on standard

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

High level actions ongoing
- Pathway analysis supported by Wessex cancer alliance to identify opportunities - to maximise capacity and improve flexibility - initially focusing on colorectal and head and neck
- ICS wide group reviewing Breast and skin pathways
- Commencing work to move towards a Dorset wide cancer PTL as per National guidance
- One stop opportunities at the start of the pathway to improve time to diagnosis- sarcoma/ lump clinic
- Improving IT support and intra-operability to assist efficacy of processes-

working across Dorset

- Escalating issues across the care groups to identify mitigating actions and plan for improvements – where constraints and delays are identified
- Weekly breach and backstop meeting to ensure all patients are regularly reviewed and actions being taken as indicated clinically
- Continuing to pursue the opportunity to introduce LA template biopsies as part of Adapt and Adopt to improve efficacy of the pathway, this would decrease the use of TRUS biopsy (as per National guidance) and free up essential theatre space –moving GA to LA .
- Working with Primary care to understand the change in demand and to address inequalities
- Working with HEE to investigate the benefit of patient navigators within certain tumour sites –where complex diagnostics are required

Health Inequalities:
A sub-group of Dorset ICS Elective Care Oversight Group has been established to develop system-wide approaches to understanding and responding to health inequalities associated with elective and UEC recovery.

A Dorset population health database was established in March 2021, this will enable access to interactive and filterable analytics of our activity by a number of metrics including deprivation, as well as other vulnerabilities including risk of social isolation, unhealthy behaviours and active safeguarding flags. This will be used to inform comms strategies, help clinicians to target hard to reach populations and support UHD to review and adapt its recovery plans and approaches to respond to health inequalities.

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

Infection Control:

- There were no new Covid-19 outbreaks reported across the Trust in March 2021
- The 2 remaining Covid-19 outbreak meetings have now closed.
- Post infection review meetings continue and learning is being collated to be shared across the Trust.
- Isolated cases of COVID-19 continued in March but the number had significantly reduced.
- National IPC guidance continues to be reviewed at the IPC Cell.
- A national focus on the learning of antibiotic use during the pandemic is being supported by the IPC team reviewing the impact of this on multi drug resistant organisms.
- The Trust Wide monitoring and Surveillance tool ICNET is now in place and enabling a higher level of surveillance across the Trust.

Clinical Practice Team:

- Moving & Handling training
- Unable to deliver the combined training requirements for clinical staff. Risk Register entry raised to 9, numerous mitigations in place
-
- Falls prevention & management
- The National Audit for Inpatient Falls (NAIF) facilities audit have been completed and submitted
- SI themes – continue to be bowel care, accurate handovers and assessment of patients on transfer
- Tissue Viability
- Expanding access to nasal cannula with integrated ear protection

across UHD, aiming to reduce medical device related injury to patients ears whilst on oxygen therapy

Nursing Care Hours per patient day (CHPPD):
The Trust remains well aligned with the national peer average for CHPPD.This was achieved through a variety of workforce initiatives:

- Registered aspirant nurses (third year student nurses);

Workforce

12 month rolling rates to March 2021:

		20/21 YTD	19/20 YTD	Variance
Turnover		10.4%	12.2%	-1.8%
Vacancy Rate		0.9%	4.4%	-3.6%
20/21 only up to Nov 20				
Sickness Rate		4.8%	4.0%	0.8%
Appraisals	Values Based	47.1%	65.9%	-18.9%
	Medical & Dental	56.1%	80.8%	-24.6%
Statutory and Mandatory Training		86.7%	89.1%	-2.4%
Staff Friends & Family Test	Caring	N/A	87.4%	
Note: 19/20 Q1 & Q2 only	Work		72.7%	

Performance:
The trend in overall **turnover** continues lower than last year and has reduced by a further 0.2% (February 10.6%). This is likely to be due to the continuing atypical market conditions and impact of lock down restrictions.

Vacancy Rate:
We continue to report high level summary data for UHD, however, ESR has now merged and we are working to unite the establishment data for both sites which will provide more accurate vacancy data from May/June.

Overall sickness levels appear to be stabilising (March 4.9%, February 4.9%). Whilst we have seen a significant reduction in staff contracting Covid-19, some of our people are experiencing post Covid-19 syndrome and work is underway to support these members of staff.

Appraisal levels for our medical and dental staff have increased slightly this month (Value Based + 3%, Medical + 0.8%) but continue to track low due to Covid and operational pressures.

Statutory and Mandatory training compliance has remained steady this month and continues in the high 80s which is encouraging as we continue to establish BEAT on the Poole site.

Factors impacting on standard:

Appraisals	Appraisals are lower than a normal year but we expect this position to improve following the launch of the new updated Appraisal process in April.

CPO Headlines:

Employee Covid Vaccinations:
The programme of second workforce vaccinations commenced on 15th March and finishes on Friday 16th April 2021.

The key statistics for employees who have had their second vaccines at the time of writing this report (15.04.2021) are as follows:

- 73.5% - substantive/fixed term workforce
- 68.5% - bank staff
- 71% - BAME staff

Walk in clinics have been made available from the RBCH site to ensure all staff have had the opportunity to receive their second vaccine. Staff that have not taken up this offer will be able to access their second dose of the vaccine from their own GP surgery.

People Operations:

- A number of Directorates are developing their post-merger reconfiguration plans and require support with their consultations. This is set to become a major element of workload throughout the coming period.
- HR Business Partners have been supporting the 4 main Tier 3+ consultations which closed on 8th April. Staff in scope will then be supported through a relevant organisational change process with the aim of having the new post holders in place by the end of June. This is a significant and complex programme of work.
- Good progress has been made with the key HR policies for UHD. These, along with the associated template letters and forms, are posted on the Bournemouth and Poole HR intranet pages. The task and finish group is currently focusing on the development of a new Civility, Respect and Dignity at Work Policy.
- The trust's Disciplinary Policies have been reviewed against a suite of recommendations that arose from a tragic incident that occurred at a London NHS trust. An additional step is being considered which will focus on the cause of an incident, linking with a Just and Learning culture.

Covid-19 Support:

- Support is being provided to managers in relation to staff who need to return to work from shielding and require temporary redeployment and/or workplace adjustments.

Resourcing:

- The NHSI target for International Nurse recruitment is challenging with the red country list growing, increasing competition from other trusts for well qualified candidates and the fluctuating cost and availability of flights. 61 of our 200 target have arrived so far.
- The NHSI HCSW recruitment target was met and we are now working to maintain these levels.
- NQ nurse recruitment is taking place - first joint event 8 May 2021
- We continue to trial new advertising options for hard to fill roles - Digital Recruitment Fairs/ Civvy Street - redeployment of forces personnel digital publication, sponsored Facebook pages etc.

Workforce Systems:

- HealthRoster has now merged and the payrolls have consolidated. Work now starts on building our UHD structures in both systems.
- Annual leave carry over and sell back data is ready to be uploaded into ESR and HealthRoster, the sell backs will be paid in the May payroll.

Temporary Workforce:

- 18K duties were requested from rostered units in March 2021 – up **7%** from previous month.
- Overall fill performance is up **7%** (Bank **7.4%** Agency nursing **3.7%)**

Health and Wellbeing:

- We continue to actively support staff with COVID-19 enhanced wellbeing offer (individual and team) and secured charity funding in excess of £500k (linked to NHSCT) to support psychologists, wellbeing practitioners, team recognition pot, H&WB interventions for disadvantaged groups
- Collaborating with Dorset ICS to ensure good integration with national Mental Health Hubs provision and agreed fast track referral to Steps2Wellbeing
- Developed and implemented a range of targeted education and support sessions for line-managers to encourage them to have 'psych savvy' conversations with their staff and teams. Also developing *Wellbeing Conversations* activity for line managers
- Growing appetite to improve the working environment alongside our planned building works so currently re-looking into alternative spaces such as 'pods' to provide 1-2-1 / individual rest and recuperation

Equality, Diversity and Inclusion: (EDI)

- Draft implementation plan to support the implementation of the EDI strategy / BDO (auditors) recommendations reviewed by EDIG (March 2021) – final planned for Workforce Strategy Committee (June 2021)
- Staff Network Group ToRs endorsed by EDIG (March 2021) with plan to provide the Staff Network Group access to funding secured during COVID-19 phase one from the NHSCT for administration and IT support
- BAME staff network representative has spoken at regional and national events to share our UHD best practice. A new video has been compiled with UHD BAME staff encouraging others to have the vaccine - appeal in their own language

Staff Engagement and Culture:

- Proposal for next stage of culture programme to include a) reward and recognition b) ensuring our staff voice is heard during COVID-19 recovery phase (*what does recovery mean to you?)* and c) supporting integration endorsed by WODG (March 2021)
- Staff Survey 2020 results received with management report identifying clear areas for action. More detailed analysis and plan for circulation / briefings in progress and for care group / department action planning (April 2021)

<u>Finance</u>

Consistent with the national interim financial framework the Trust 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, for the six-months ending 31 March 2021, the Trust has delivered a favourable variance of £5.7 million reporting an aggregate surplus of £145,000. This variance resulted from lower than planned expenditure in relation to ongoing COVID-19 costs, winter preparedness and the recovery of elective services; together with additional income to off-

	set the continued reduction in non-NHS income (£3.3 million) and reimburse independent sector costs for elective activity (£2 million). Within this position, cost improvement savings of £1.6 million have been delivered consistent with the budgetary target. As at 31 March 2021 the Trust has delivered a £5.131 million capital underspend as part of the overall ICS capital envelope. Furthermore, the Trust agreed not to draw STP Wave 1 Capital funding of £7.122 million which will be available next year. The Trust is currently holding a consolidated cash balance of £99.7 million at 31 March 2021. Although the current cash position is strong, this is fully committed against the Trusts 6 year capital program and thus the cash position continues to be monitored closely.
Options and decisions required: *Clearly identify options that are to be considered and any decisions required*	No decisions required
Recommendations: *Clearly identify the recommendation being put to the board*	**Members are asked to:** Note • The areas of the Board focus for discussion • The impact of wave 3 Covid on inpatients on operational patient flow and the impact of cancellation of routine elective activity.
Next steps: *Clearly identify what will follow the Board's discussion/decision*	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)	**Risks scoring ≥12:** **UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (1343) – COVID -19 impact on staffing **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **UHD 1460** – UEC national metrics **UHD 1429** – Ambulance handovers

	UHD 1053 –Long Length of Stay / Discharge to Assess /RTR **UHD 1430** – ED workforce **UHD 1074** - Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards **UHD 1292** – Outpatient Follow-up appointment backlog. Insufficient capacity to book within due dates **UHD 1347** – Financial Control Total 2020/21.This entry highlights the potential risk of the Trust failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme. **UHD 1416** – GIRFT & Model Hospital. This entry highlights the risk of not achieving the efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision
CQC Reference:	All 5 areas of the CQC framework

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

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




March 2021

Created April 2021

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	ytd	ytd var	trend
SAFE														
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	149	87	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	45	16	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	34	-12	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	15,877	2	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	1	
		MSSA		1	2	3	9	8	4	6	4	51	-12	
		C Diff		7	6	1	3	1	2	9	3	53	13	
		E. coli		3	12	5	8	2	11	3	3	65	30	
EFFECTIVE														
Mortality	HSMR Latest	(Dec 20 - UHD)												
	Patient Deaths	YTD		207	185	265	244	249	469	299	217	2646	-166	
	Death Reviews	Number		86	65	66	53	54	99	32	2	481	n/a	
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	412	17	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	199	-53	
CARING														
	Complaints Received			57	48	51	56	62	53	53	51	570	159	
	Complaint Response in month			57	48	51	48	49	43	59	59	549	207	
	Section 42's			0	2	0	0	0	0	1	0	27	7	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	92%	-	
WELL LED														
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	31	-10	
	Red Flags Raised*			31	47	51	43	73	129	51	28	506	-62	
	*different criteria across RBCH & PHT													
	Overall CHPPD			9.5	8.8	9.0	9.4	9.4	8.3	9.4	9.3	10.1	2.0	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	0	0	0	0	
People	Turnover			10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	9.20%	10.4%	-1.8%	
	Vacancy Rate *(only up to Oct 2020)*			1.0%	0.7%	1.3%	-	-	-	-	-	0.9%	-3.6%	
	Sickness Rate			4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	4.9%	4.8%	0.8%	
	Appraisals	Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	62.9%	47.1%	-18.9%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	56.0%	-24.6%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	89.7%	-2.4%	

RESPONSIVE

Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	221	-80
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	1052	-324
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	60%	7%
	**infection eNA assessment*	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	72%	N/A
	went live at RBCH	MUST		64%	64%	63%	65%	61%	57%	63%	63%	63%	8%
	during April 20	Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	59%	8%
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%	58.2%		
	Waiting list size		42,587	41,172	43,123	44,320	44,349	44,117	44,615	45,524	47,133		
	Waiting List size variance compared to Mar 19 %		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%	10.7%		
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672	12,408		
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006	6,727		
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325	5,595		
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3	20.1		
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%		
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%		
	NOFs (Within 36hrs of being clinically fit - CCG)		95%	69%	10%	50%	74%	56%	67%	90.0%	82.0%		
Outpatients	**Referral Rates**												
	GP Referral Rate year on year +/-		-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%	-22.4%		
	Total Referrals Rate year on year +/-		-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%	-17.2%		
	Outpatient metrics												
	Overdue Follow up Appts			13,652	13,941	13,722	13,099	13,941	14,883	15,775	15,669		
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54	1.44		
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%	5.0%		
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%	5.4%		
	30% reduction in face to face attendances												
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%	42.5%		
DM 01	**Diagnostic Performance (DM01)**												
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%	2.9%		
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-			
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	71.6%	80.0%		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.2%	83.8%		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0	6.0		
	Clinician seen <60 mins			4065	4399	4664	4484	4385	4526	5136	0		
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205		
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206		
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0		
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072		
	ED attendance Growth (YTD)			-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%	-21.1%		
SWAST SCAST	Ambulance handover growth (YTD)					-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%		
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190		
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20		
Patient Flow	Emergency admissions growth (YTD)			-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%	-13.4%		
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%		
	Stranded patients:												
	Length of stay 7 days			380	394	385	311	443	311	347			
	Length of stay 14 days			197	214	219	155	242	155	184			
	Length of stay 21 days		108	108	126	132	86	144	86	105			
	Non-elective admissions			6089	6279	5673	6034	5231	6034	6130			
	> 1 day non-elective admissions			3796	3932	3554	3686	3521	3686	3737			
	Same Day Emergency Care (SDEC)			2291	2346	2118	2344	1710	2344	2387			
	Conversion rate (admitted from ED)		30%	34.40%	36.10%	38.30%	36.90%	42.30%	36.90%	37.00%			

Quality - SAFE

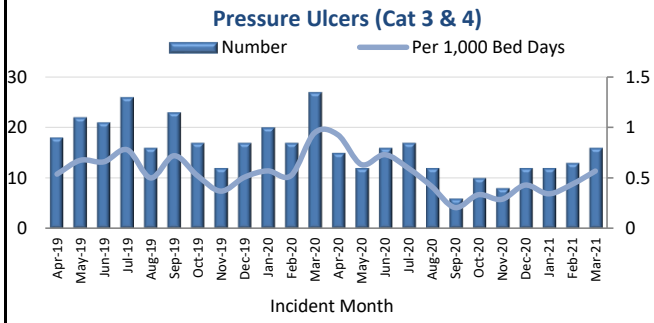
Commentary on high level board position

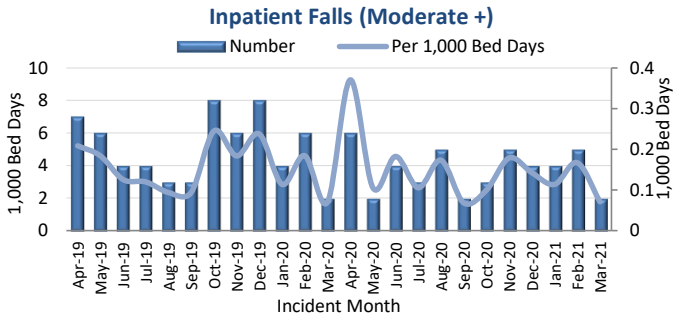
- Two (2) Serious Incidents were reported in March 21 - (1) Delayed diagnosis of rectal cancer. Scoping meeting held and RCA in progress. (1) Maternity case meeting HSIB criteria. Baby born requiring resuscitation, transferred to NICU with meconium aspiration and Persistent Pulmonary Hypertension of the Newborn, ventilated.
- YTD total (37) below total for previous year 2019/20 (50). However the number of reportable Never Events is above total for previous year.
- The Staff Survey results (published March 21) - Safety Culture Scores: Poole 6.7, RBCG 7.0, Average 6.8, Worst 6.1, Best 7.4.
- There has been a slight increase in new category 3 and 4's pressure ulcers associated to medical devices and continence care. The reduction in falls is a result of less ward transfers due to IPC requirements and therefore patients being cared for within their indicated specialities.

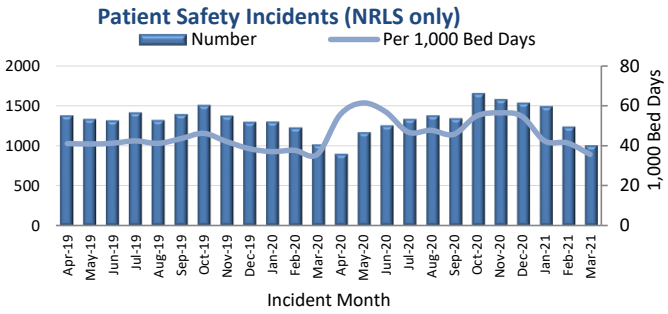
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	149	236	87
	Per 1,000 Bed Days	0.46	0.60	0.14
Inpatient Falls (Moderate +)	Number	45	61	16
	Per 1,000 Bed Days	0.14	0.16	0.02
Medication Incidents (Moderate +)	Number	34	22	-12
	Per 1,000 Bed Days	0.11	0.06	-0.05
Patient Safety Incidents (NRLS only)	Number	15,877	15,879	2
	Per 1,000 Bed Days	49.06	40.61	-8.45
Hospital Acquired Infections	MRSA	0	1	1
	MSSA	51	39	-12
	C Diff	53	66	13
	E. coli	65	95	30

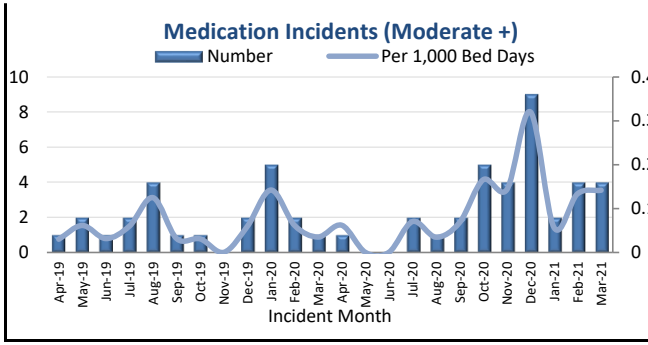
High Level Trust Performance

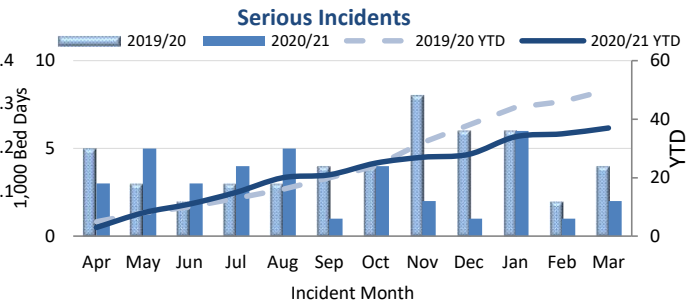


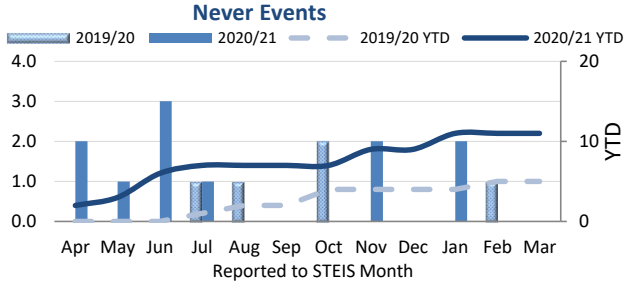




0 (Feb 21) MRSA 0 (Mar 21) | 6 (Feb 21) MSSA 4 (Mar 21) | 9 (Feb 21) C Diff 3 (Mar 21) | 3 (Feb 21) E. coli 3 (Mar 21)







Quality - RESPONSIVE

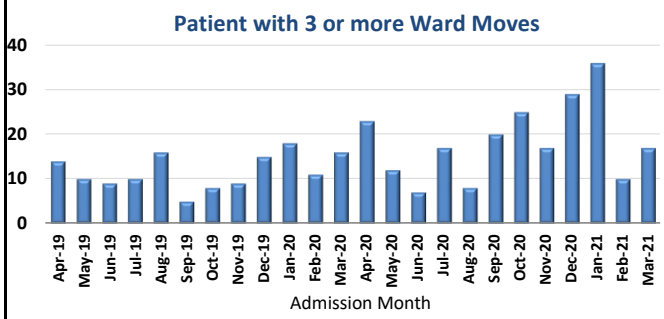
Commentary on high level board position

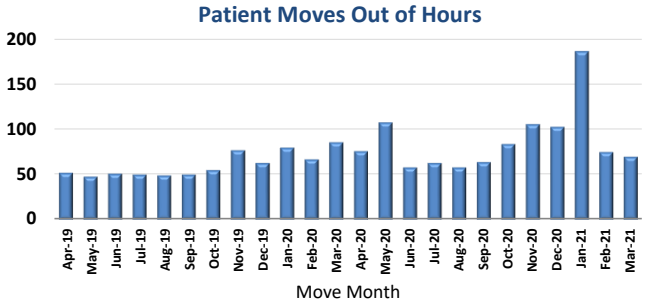
- As the Trust eased back from high numbers of Covid-19 patients to more routine work, a number of complex ward moves were required in order to maintain good infection prevention control practices and patient safety. The slight rise in numbers of patients experiencing 3 or more moves is believed to be linked to this.
- Reporting on mixed sex accomodation remains on hold nationally, the Trust however continues to aspire to maintain this standard
- eNA compliance has continued to improve since the dip in January, particular improvement noted on the Poole site. Work continues to include eNA compliance in incident reviews and ward improvement plans. The IT Nurse Specialists have now joined the Clinical Practice Team and will continue to support the embedding of eNA assessments.

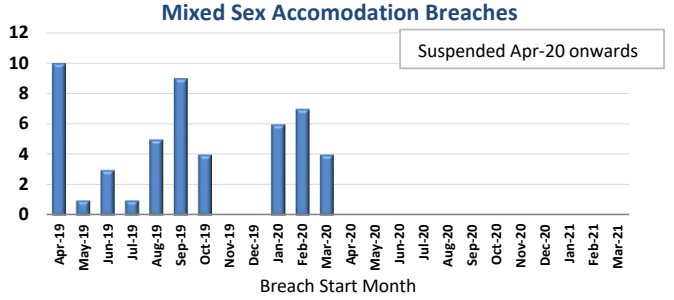
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)		221	141	-80
Patient Moves Out of Hours (Non-Clinically Justified Only)		1052	728	-324
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid		0	50	N/A
ENA Risk Assessment				
**infection eNA assessm went live at RBCH during April 20*	Falls	60%	53%	7%
	Infection*	72%	17%	N/A
	MUST	63%	55%	8%
	Waterlow	59%	53%	6%

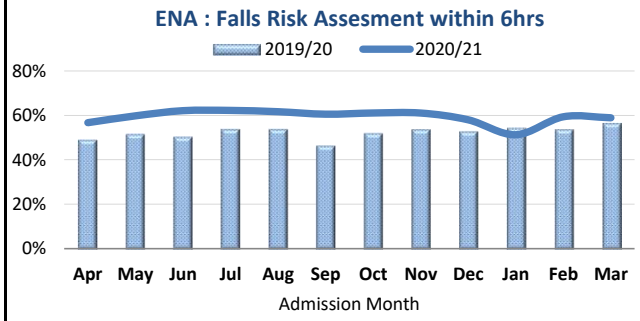
High Level Trust Performance

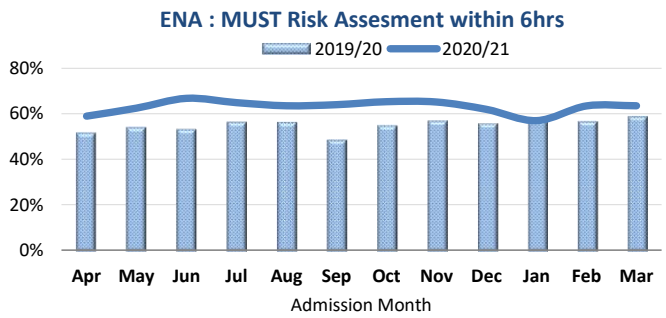


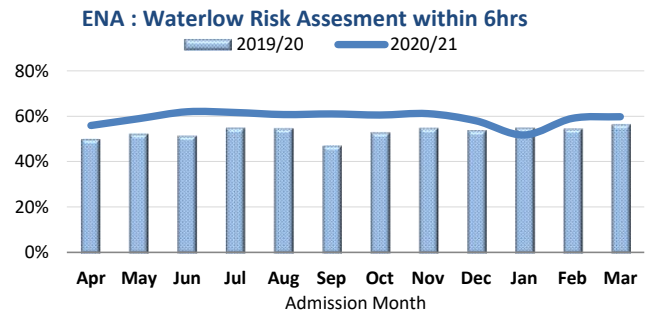




59.3% (Feb 21) Falls 58.9% (Mar 21) | 61.6% (Feb 21) Infection 63.6% (Mar 21) | 63.4% (Feb 21) MUST 63.5% (Mar 21) | 59.0% (Feb 21) Waterlow 59.8% (Mar 21)







Quality - EFFECTIVE AND MORTALITY

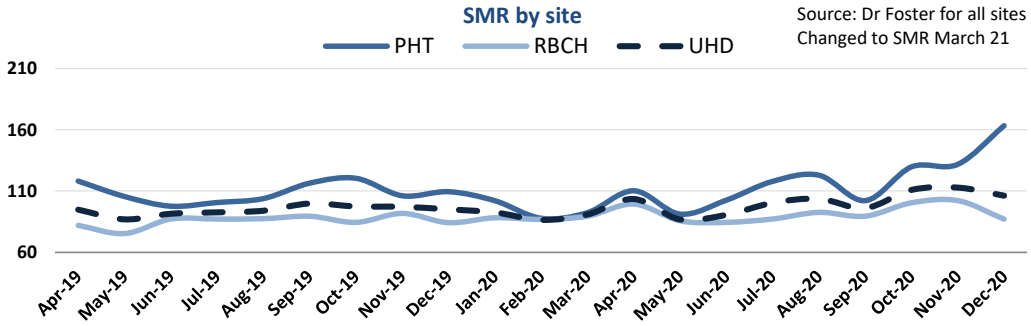
Commentary on high level board position

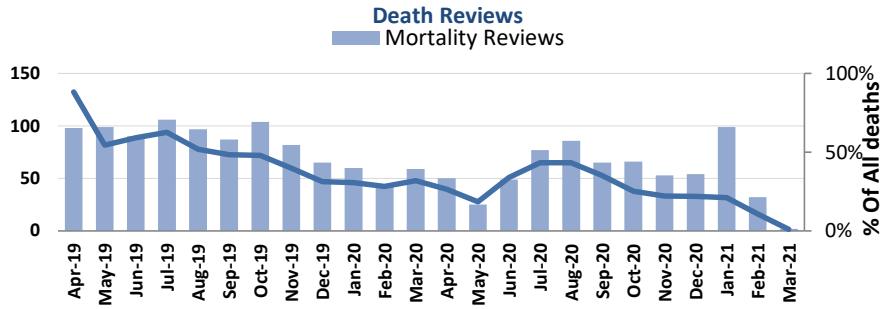
- 100% of all inpatient deaths were reviewed by a Medical Examiner in month. However the number of formal case note mortality reviews has reduced again in month due to covid activity. There remains still clinical engagement in learning from deaths at the Trust Mortlaity Surveillance Group. A Request for Change to roll out the emortality system at RBCH has been approved and a project group will be established to plan the work required.

High level Board Performance Indicators

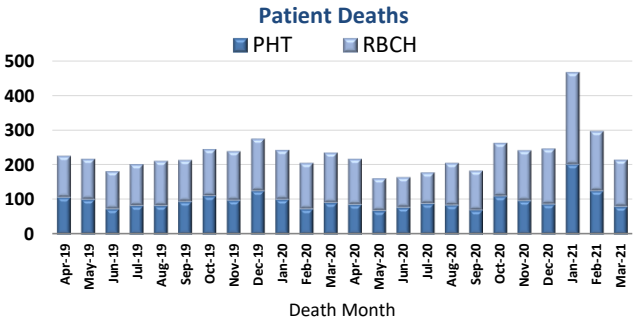
		20/21	19/20	Variance
SMR (Source: Dr Foster for all sites)	Latest (Dec 20 - UHD)	106.2	95.1	
Patient Deaths	YTD	2863	2717	146
Death Reviews	Number	658	991	N/A
Note: 3 month review turnaround target	Percentage	24%	46%	
Deaths within 36hrs of Admission		449	436	13
Deaths within readmission spell		215	277	-62
Patient readmitted within 5 days				

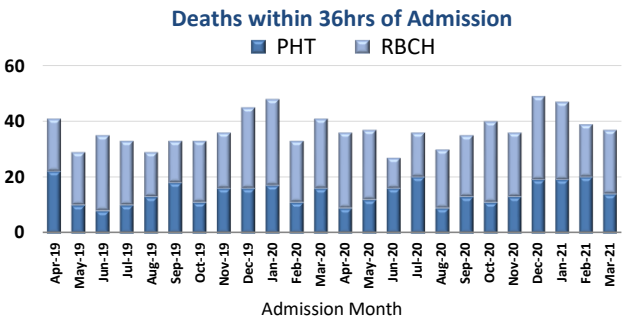
High Level Trust Performance

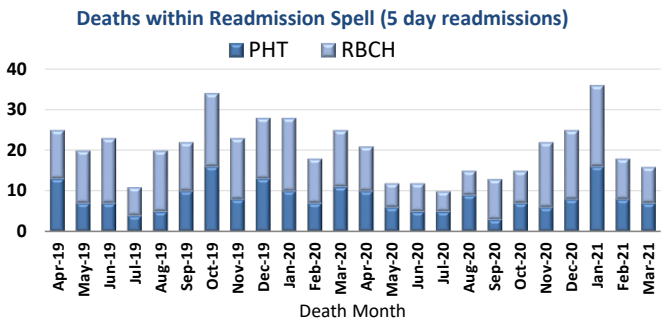




109.9 (Oct 20) SMR 125.4 (Nov 20) | 299 (Feb 21) Patient Deaths 217 (Mar 21) | 22% (Dec20) Deaths Reviewed 21% (Jan 21)







Quality - CARING

Commentary on high level board position

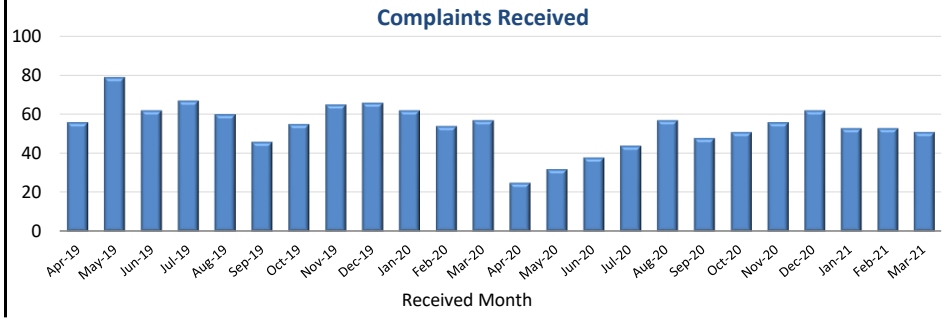
- The overall Friends and Family Test rating of good/very good reamins fairly consistent at 93.1%
  FFT Comment include: *Amazing staff, great ward host. Everyone does their best even though they are busy and are always happy to help with anything. (RBH – Ward 17)*
- This month, the number of complaint responses completed continues to improve and again has exceeded the number of complaints received; this is showing an overall improvement and a slow recovery from the delays caused during and due to the pandemic.

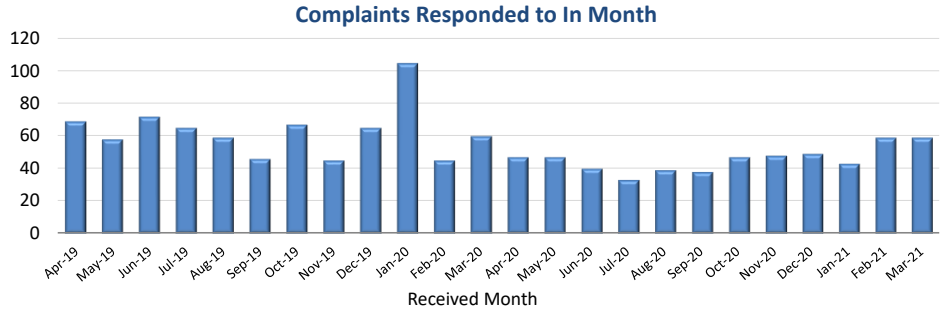
High level Board Performance Indicators

	20/21 YTD	19/20 YTD	Variance
Complaints Received	570	729	159
Complaint Response Compliance	TBC		
Complaint Response in month	549	756	207
Section 42's	27	34	7
Friends & Family Test	92%	N/A	-

Return changed 20/21

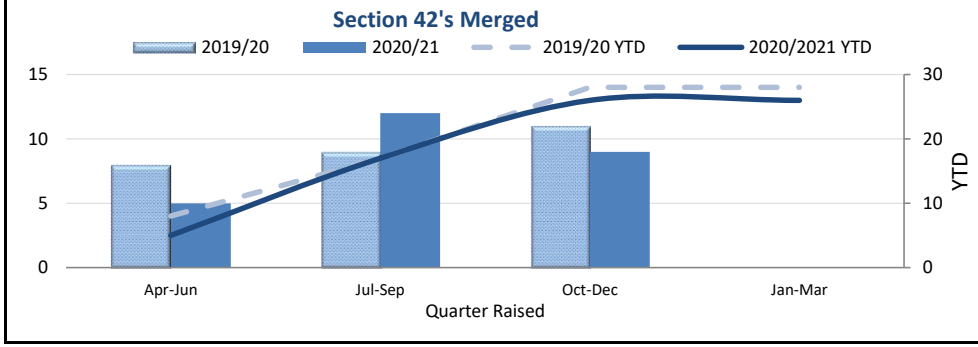
High Level Trust Performance

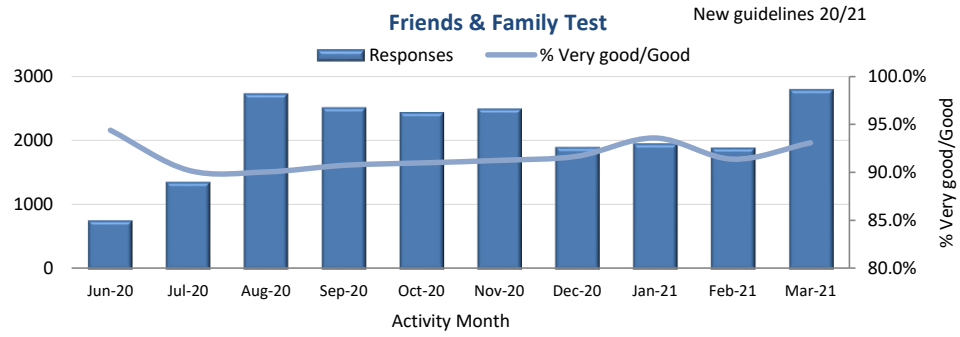




53 (Feb 21) > Complaints Received > 51 (Mar 21)

59 (Feb 21) > Complaint Responses > 59 (Mar 21)





Quality - WELL LED

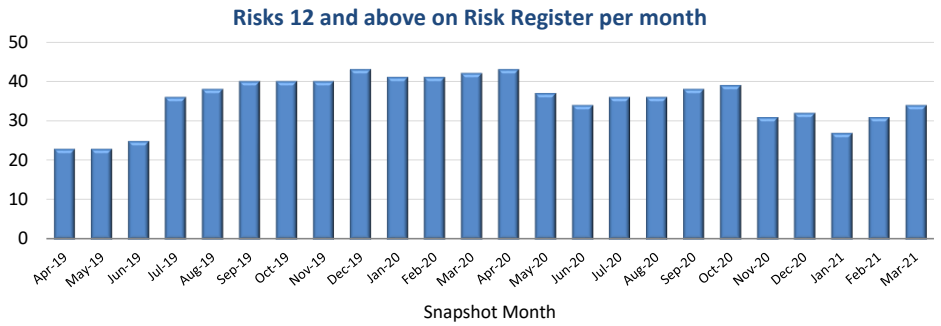
Commentary on high level board position

- Work was completed on time to move all risks from the RBCH Datix system to the Poole system by the 1/4/21. All risks have been successfully moved.
- All risks on the risk register have been linked UHD monitoring committees and new standard reports developed to enable close review at Board and Board sub committees.
- A reduction in redflags on the Poole Hospital site in February and March is linked to the implementation of the new redflag policy and was anticapted due to changes in the reporting criteria.
- The overall CHPPD data scores well against the national average of 9.1 for all nursing , midwifery and AHP staff. The Trust achieved the zero Health Care Support Workder target on trajectory and received full funding. On-going recruitment continues, with focused work on International Nurses and Registered Nurse Apprentices.

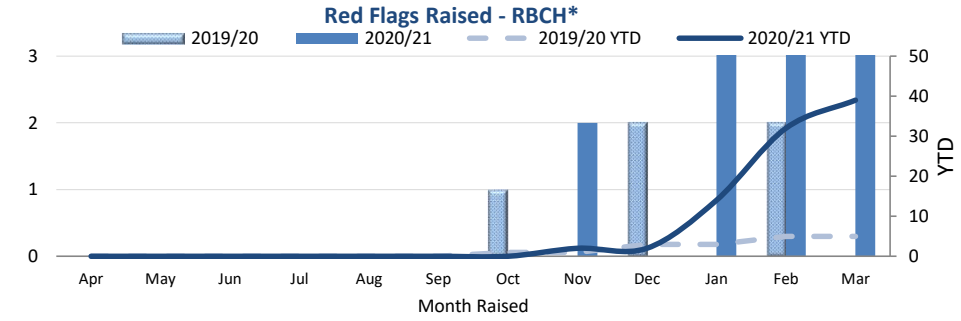
High level Board Performance Indicators

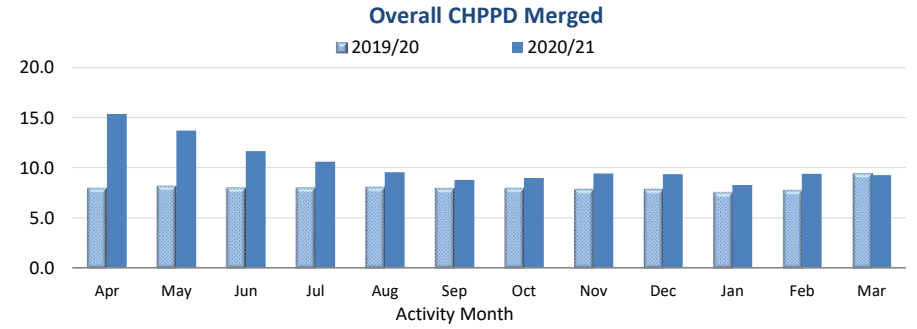
	20/21 YTD	19/20 YTD	Variance
Risks 12 and above on Register	31	41	-10
Red Flags Raised* *different criteria across RBCH & PHT	506	568	-62
Overall CHPPD	10.1	8.1	2.0
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance

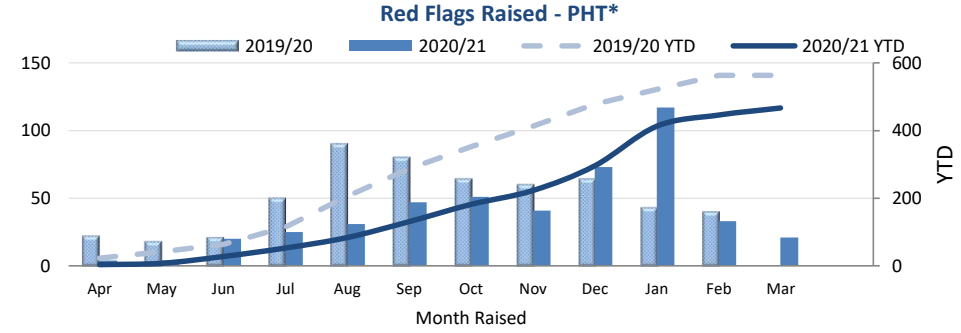


27 (Jan 21) Risks 12+ 31 (Feb 21)





9.4 (Feb 21) Overall CHPPD 9.3 (Mar 21)



Workforce

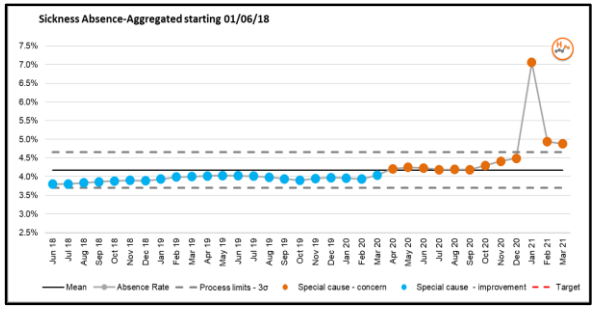
Commentary on high level board position

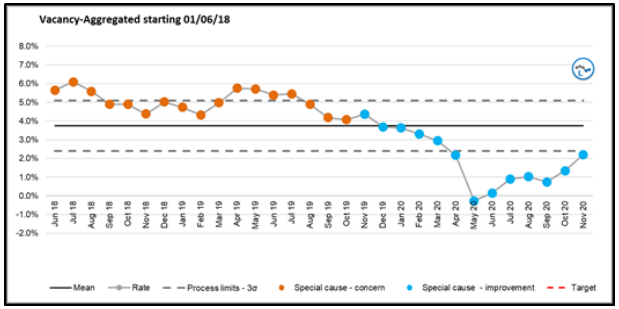
- The trend in **overall turnover** continues lower than last year and has reduced by a further 0.2% (February 10.6%). This is likely to be due to the continuing atypical market conditions and impact of lock down restrictions
- We continue to report high level summary **vacancy** data for UHD, however, ESR has now merged and we are working to unite the establishment data for both sites which will provide more accurate vacancy data from May/June.
- **Overall sickness** levels appear to be stabilising (March 4.9%, February 4.9%). Whilst we have seen a significant reduction in staff contracting Covid-19, some of our people are experiencing post Covid-19 syndrome and work is underway to support these members of staff.
- **Appraisal levels** for our medical and dental staff have increased slightly this month (Value Based + 3%, Medical + 0.8%) but continue to track low due to Covid-19 and operational pressures. We expect this position to improve following the launch of the new updated Appraisal (Values Based) process in April.
- **Statutory and Mandatory training** compliance has remained steady this month and continues in the high 80s which is encouraging as we continue to establish BEAT on the Poole site.
- The programme of **second workforce vaccinations** commenced on 15th March and finishes on 16th April. 73.5% of our substantive/fixed term workforce have now had the second covid-19 vaccine, 68.5% of our bank staff and 71% of BAME staff.
- During March we saw a 7% increase in requests from rostered units for **temporary workforce** Overall fill performance was up 7% (Bank 7.4%, Agency nursing 3.7%).

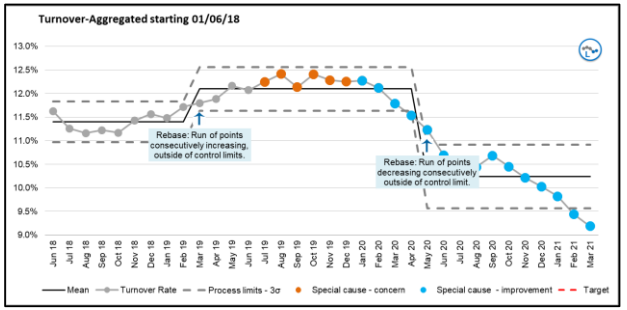
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Turnover		10.4%	12.2%	-1.8%
Vacancy Rate *20/21 only up to Nov 20*		0.9%	4.4%	-3.6%
Sickness Rate		4.8%	4.0%	0.8%
Appraisals	Values Based	47.1%	65.9%	-18.9%
	Medical & Dental	56.1%	80.8%	-24.6%
Statutory and Mandatory Training		86.7%	89.1%	-2.4%
Staff Friends & Family Test *Note: 19/20 Q1 & Q2 only*	Caring	N/A	87.4%	
	Work		72.7%	

High Level Trust Performance





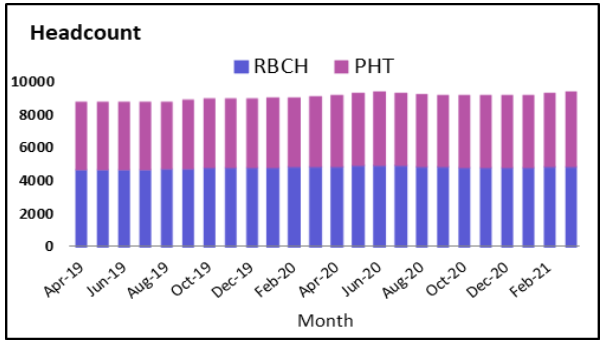


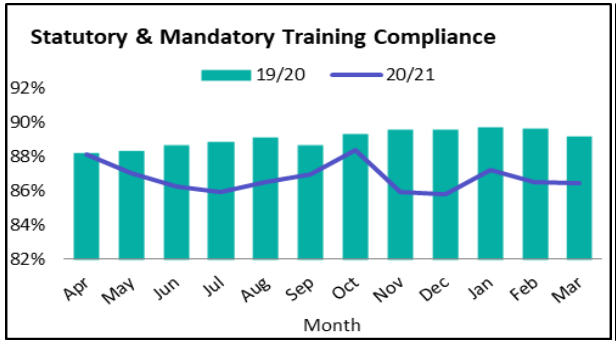
62.7% (Feb 21) → Appraisals (Medical) → 56.8% (Mar 21)

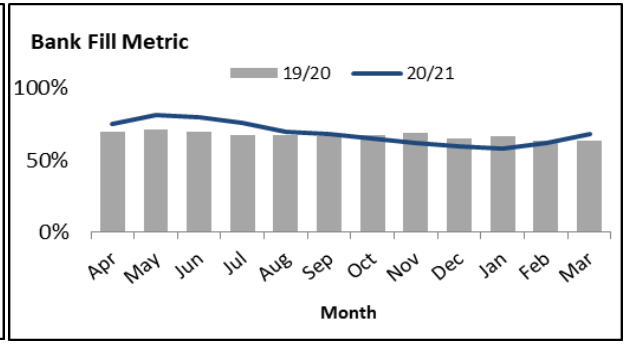
63.1% (Feb 21) → Appraisals (Values) → 62.9% (Mar 21)

9.4% (Feb 21) → Turnover → 9.2% (Mar 21)

4.9% (Feb 21) → Sickness → 4.9% (Mar 21)



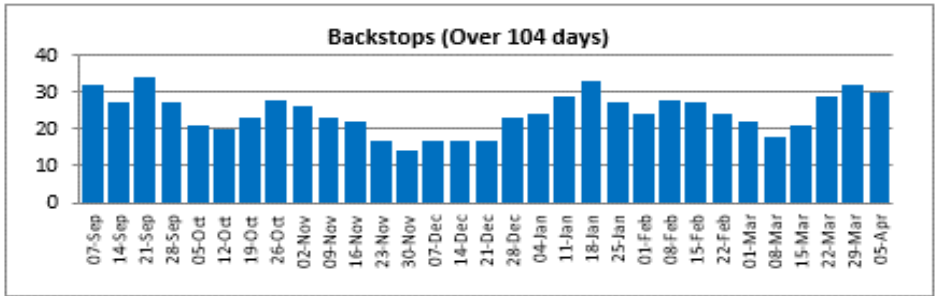


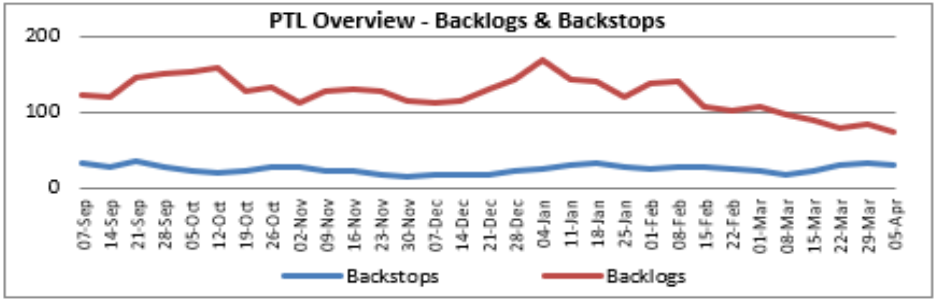


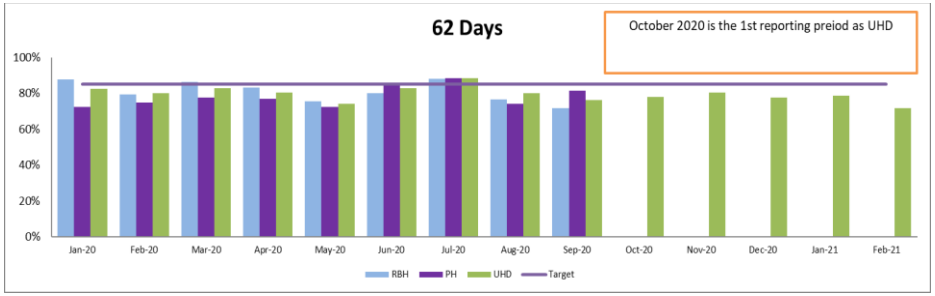
Cancer - Actual February 2021 and Forecast March 2021

Commentary on high level board position

Overall in month the position for the trust against the key performance indicators saw an improving position, however due to a significant increase in 2 week wait referrals this position will be challenging to maintain going into April. The backlog position is steadily improving (2.86% of PTL) however there remains pressure within urology, upper GI and skin. This pressure is also reflected in the 104 day position(1.34% of PTL) with urology and upper GI reporting a slight increase. For context, Wessex Cancer Alliance are reporting 3.3% of the PTL over 62 days which is the best position nationally (UHD represents over 31% of Wessex Cancer Alliance activity). Dorset wide meetings are arranged to discuss an ICS approach to manage inequity for pathways currently under significant pressure.

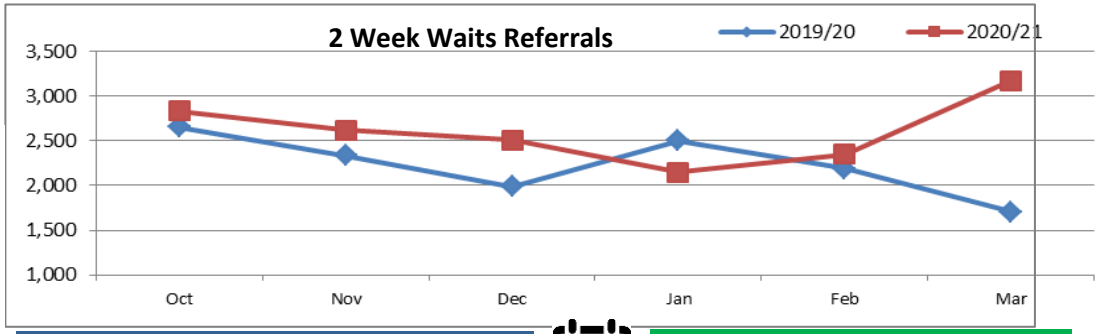




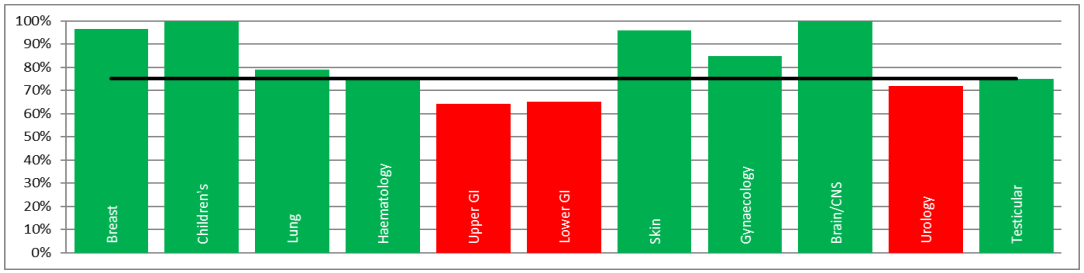


High level Board Performance Indicators & Benchmarking

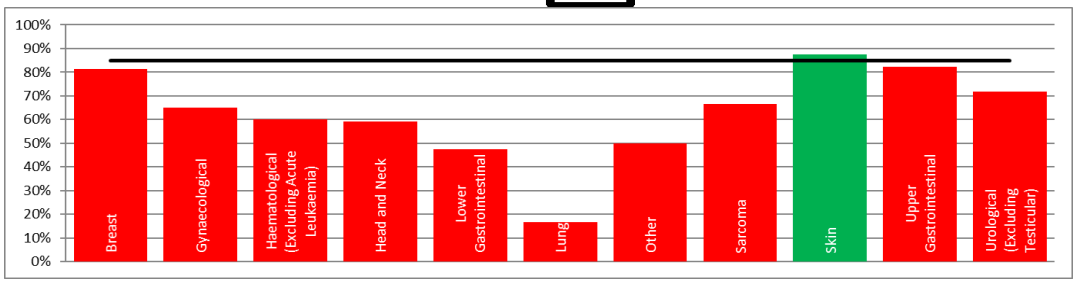
Cancer Standards	Standard	UHD Feb-21	Predicted Mar-21
31 day standard	96%	94.5%	97.8%
62 day standard	85%	71.6%	80.0%
28 day faster diagnosis standard	75%	80.2%	83.8%



Target 75% | **28** | **UHD: Feb 2021: 80.2%**



Target 85% | **62** | **UHD: Feb 2021: 71.6%**



Emergency

Commentary on high level board position

Despite almost 500 more Ambulance conveyances in March '21 than received in February '21, both Departments have sustained improvements in >60 minute ambulance handover times, with 20 waiting over 60 minutes (Feb 36, Jan 203). The >30 min handover times has deteriorated slightly when compared to February with 190 Ambulances waiting longer than 30 minutes to hand over (Feb 173, Jan 261), though overall improved average handover times have been sustained. Both departments saw increased attendances (c3000 more than previous month) but made significant improvements in overall mean time compared to February, with both only narrowly missing the 200 minute mean time standard.

No patients waited in either department for more than 12 hours after a decision to admit, with significant improvements in the number of patients in either department for more than 6 hours (1072 in month compared to 1322 in Feb and >2000 in Jan). In anticipation of future new UEC standards, both departments have implemented a 'zero tolerance' approach to patients reaching 12 hours from arrival at the Emergency Department, with hot debriefs at Care Group level for any exceptions.

UHD has now implemented a live ED operational dashboard and daily reporting covering both departments 'side by side'. This is supporting the transformation and improvement works across the departments, including identifying opportunities for benchmarking and shared learning.

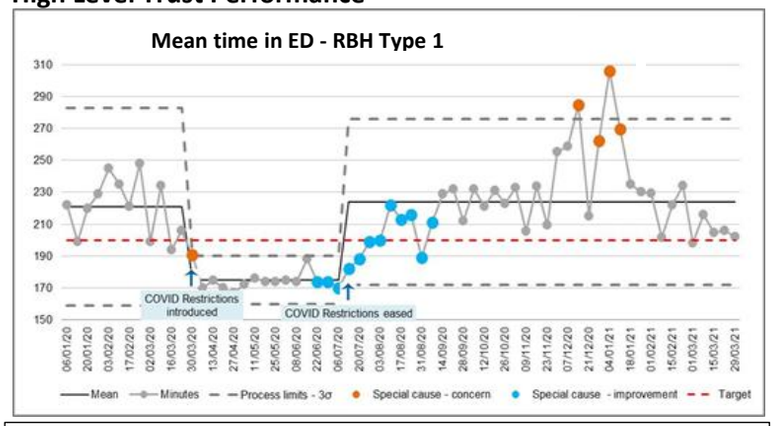
High level Board Performance Indicators

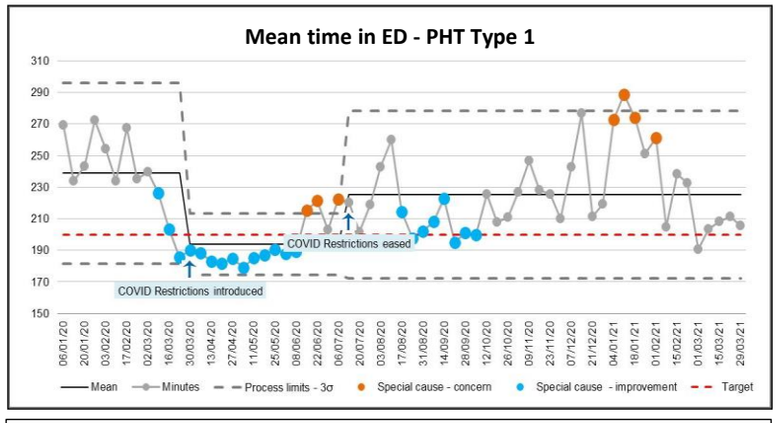
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	6
Clinician seen <60 mins		45.2%
PHT Mean time in ED	200	205
RBCH Mean Time in ED	200	206
Patients >12hrs from DTA to admission	0	0
Patients >6hrs in dept		1072
ED attendance Growth (YTD)		-21.1%
Ambulance Handover		
Ambulance handover growth (YTD)		-4.4%
Ambulance handover 30-60mins breaches		190
Ambulance handover >60mins breaches		20
Emergency Admissions		
Emergency admissions growth (YTD, all types)		-13.4%

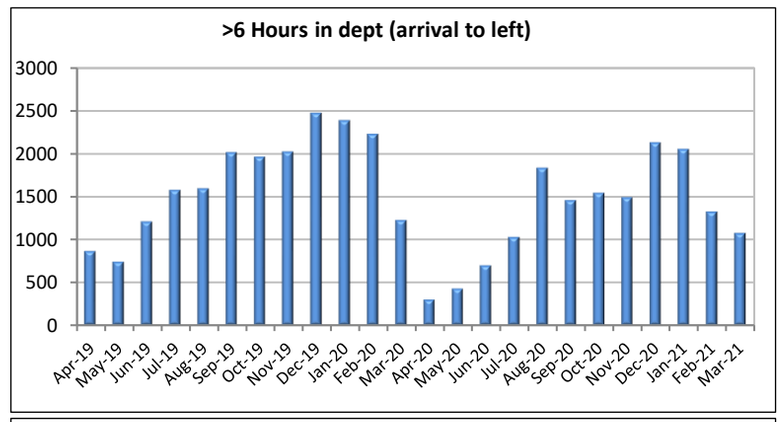
5 mins Feb-21 → Mean time to initial assessment → 6 mins Mar-21

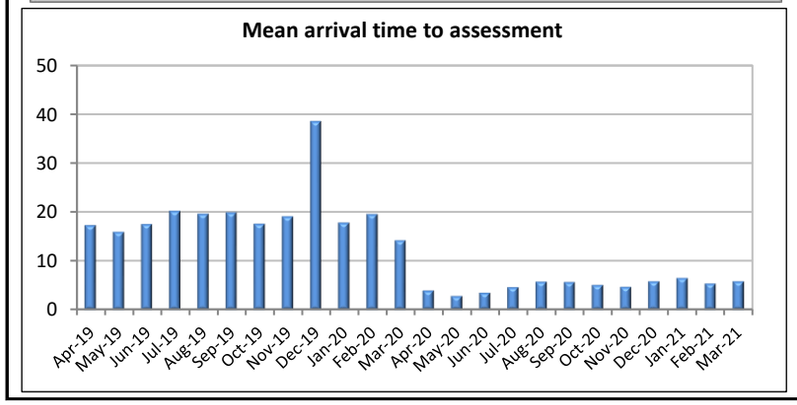
228 mins Feb-21 → Mean time in Dept. RBH & PHT → 205 mins Mar-21

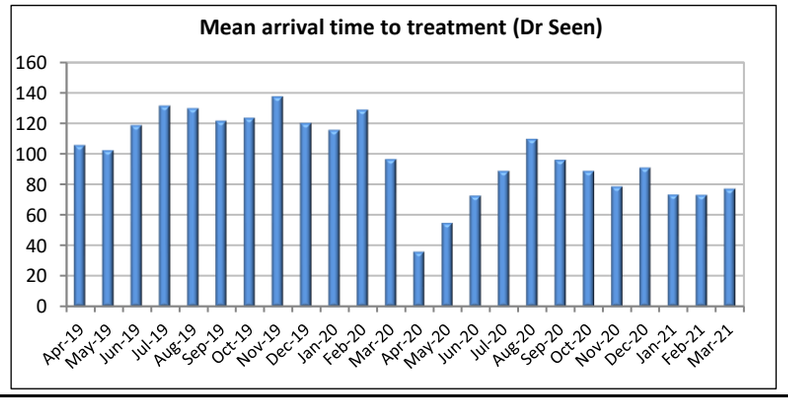
High Level Trust Performance

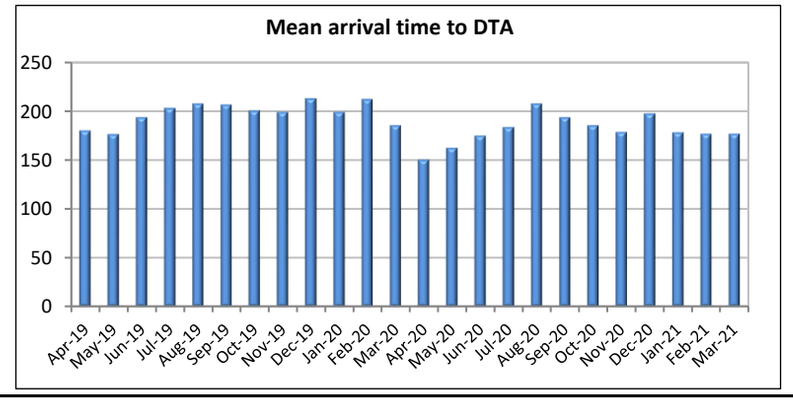












Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of March 2021, the Trust's 18 week RTT performance is **58.2**% against the 92% standard, with **5,595** patients waiting more than 52 weeks.

The performance is a result of cancellation of routine elective activity over the last 12 months when the Trust had to prioritse and redploy workforce to support the response to managing the COVID-19 pandemic. A contribuitng factor to the rise in waiting lists size is the transfer of the routine waiting list and activity from Dorset Healthcare University NHS FT as part of the system recovery plan.

Specialty level recovery plans and 52 ww improvement trajectories have been agreed and are overseen by the OPAD programme of elective care recovery. Focus for improvement is to reduce the number of non-admitted patient pathways >52 weeks by restoring outpatient activity at scale where it is safe to do so and to reduce the number of admitted patient pathways >52 weeks by increasing treatment capacity using the Independendent Sector and Insourcing sessions at weekends.

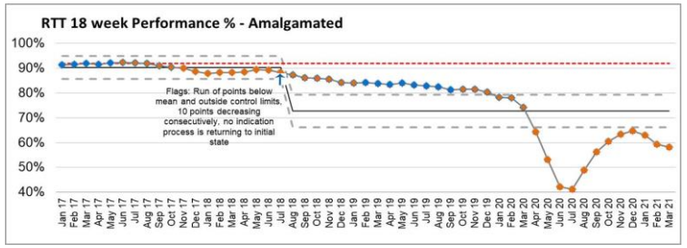
Theatre utilisation
The current theatre utilisation rate is improving as routine elective activity is being restored.

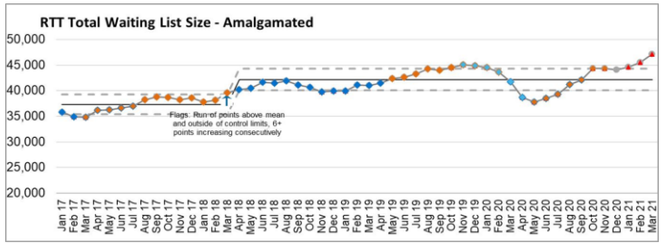
Trauma
82 % of NOF patients that were clinically fit for surgery were treated in 36 hours, a reduction from 90% last month which is due to rising trauma cases as COVID-19 lockdown pressures ease.

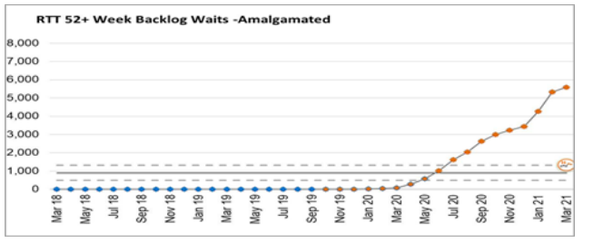
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust
Referral To Treatment		
18 week performance %	92%	58.2%
Waiting list size	42,587	47,133
Waiting List size variance compared to Mar 19 %	0%	10.7%
No. patients waiting 26+ weeks		12,408
No. patients waiting 40+ weeks		6,727
No. patients waiting 52+ weeks (and % of waiting list)	11.9%	5,595
No. patients waiting 78+ weeks		979
Average Wait weeks	8.5	20.1
Theatre metrics		
Theatre utilisation - main	80%	73%
Theatre utilisation - DC	85%	67%
NOFs (Within 36hrs of being clinically fit - CCG)	95%	82%

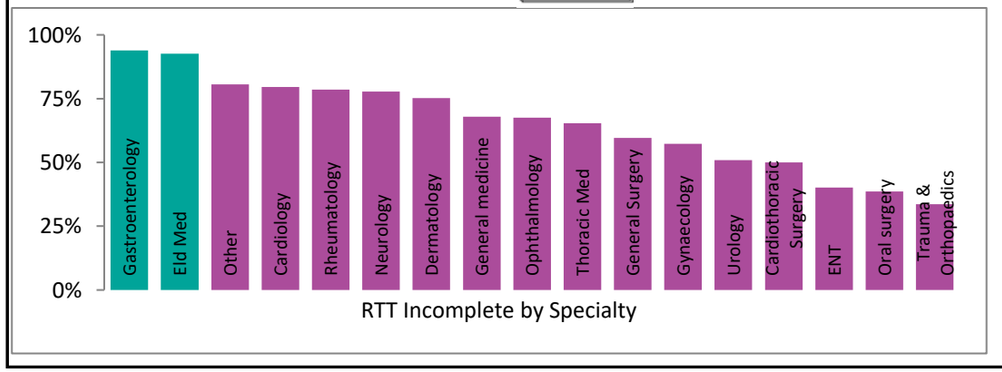
High Level Trust Performance



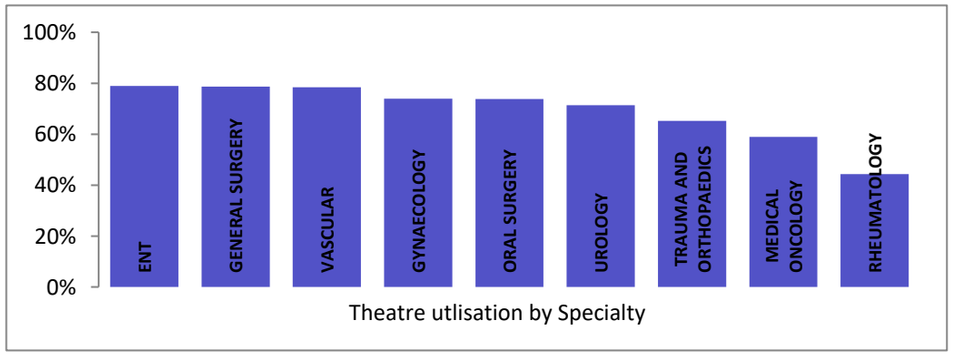




RTT Incomplete 58.2% <18weeks 18 WEEKS (Last month 59.3%) Target 92%



Theatre Utilisation 72% (Last month 66%)



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 **58.2%** of all patients were seen and treated within 18 weeks at the close of March 2021.
The overall waiting list (denominator) was **47,133** which is higher than previous months and 10.7 % above the March 2019 waiting list of 42,587.

At the end of March 2021 5,595 patient pathways were reported as having exceeded 52 weeks.

March 2021 (compared with previous month)

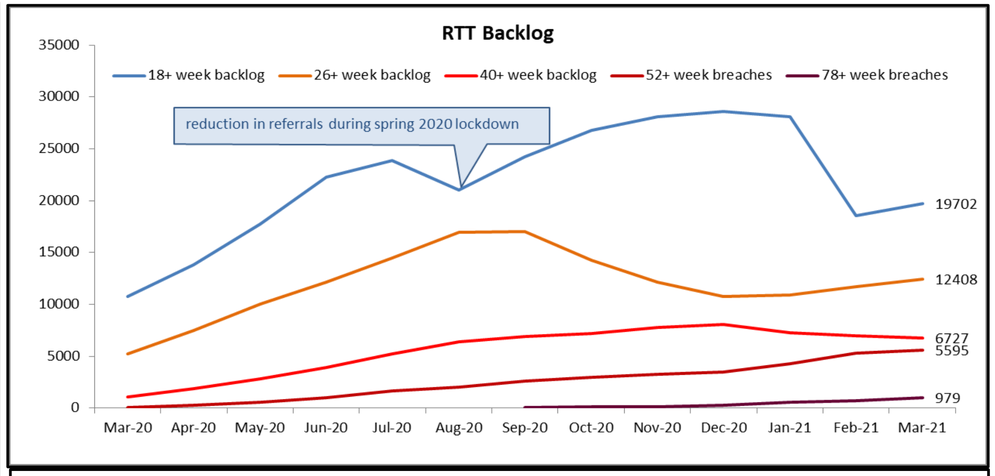
19,702 increase > 18 weeks
12,408 increase > 26 weeks
6,727 decrease > 40 weeks
5,595 increase > 52weeks
979 increase > 78 weeks

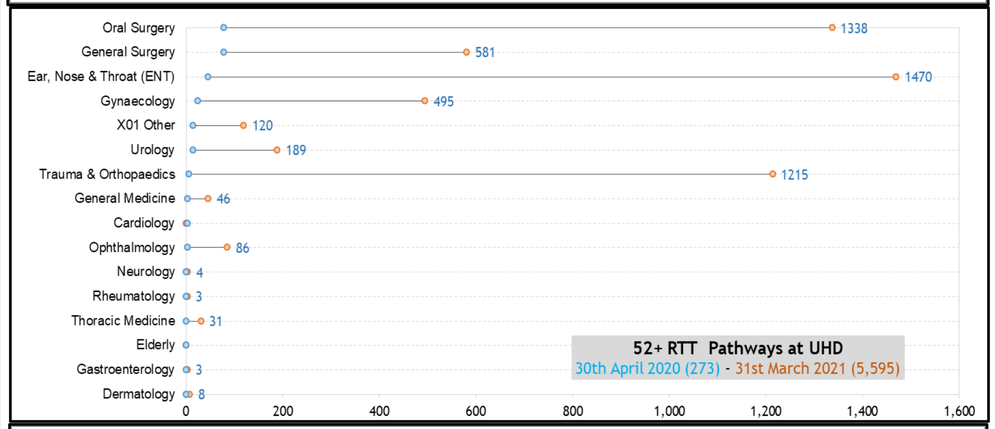
From October 2020 all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks, and a RCA for any patient waitng > 104 weeks.

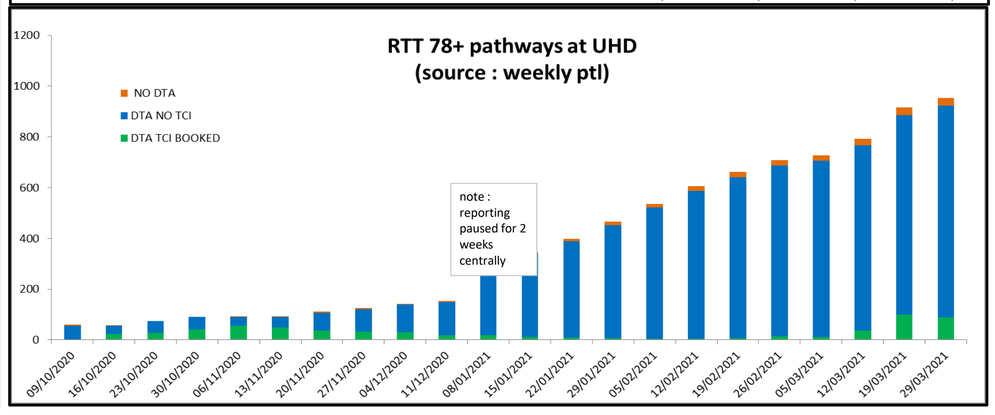
During the Trust response to managing the COVID-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in routine elective activity including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

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

- Royal College guidelines on the numbers of patients that can be safely seen during COVID -19 pandemic leading to many patients being deferred for both outpatient appointments and routine elective surgery
- Patients chosing not to attend hospital due to concerns about COVID-19, many patients choosing to wait until the pandemic is over or they have been vaccinated.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity in mnay specialites.
- Clinical prioritisation of urgent and cancer pathwaysduring period of reduced capaciy / activity
- Workforce have been redployed to support the response to managaing COVID-19, notably mnay theatre staff and clinicians were redployed to support critical care
- Lack of capacity to book routine elective patients for tretaement as shown by the number of patients waiting a TCI date in the RTT > 78 week chart.







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

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

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

- Validation & clincial priortisation of all waiting lists; active FU Op and Planned PTLs
- Single PAS project to support merging teams to manage single UHD waiting lists
- Think Big Outpatient recovery at scale working across the Dorset ICS system
- 52 ww Trajectory planning to manage /monitor improvements
- Demand & Capacity planning
- Specialty PTL Reviews and action plans
- Access Policy and SOP review to include retarinign of all staff in RTT processess
- Improving BI reprots to support and monitor improvement
- Patient Pathway Coordination
- Review of admissions processess and governance
- Operational Planning
- Supporting Dorset ICS with single PTLs and taking on activity from other providers eg transfer of DHUFT routine activity and wait list
- Health Inequalities

Care Groups are leading on specialry level improvement plans:

- Theatre Utilisation Group established across UHD
- Outpatient Transformation
- Creating additional capacity using local ISP providers and / or Insourcing companies
- Reviewing clincical and ICP guidance to ensure effective use of sessions
- Maximising potential and harmosising capacity across all sites

Health Inequalities
National planning guidance includes a requirement to recover the maximum elective activity possible taking into account opportunities to transform service delivery. A sub group of Dorset ICS Elective Care Oversight Group has been established to develop system-wide approaches to understanding and responding to health inequalities associated with elective and UEC recovery.
UHD made the first submission of linked data to the Dorset Information and Intelligence Service (DiiS) population health database in March 2021, this will enable access to interactive and filterable analytics of our activity by a number of metrics including deprivation, as well as other vulnerabilities including risk of social isolation, unhealthy behaviours and active safeguarding flags. This will be used to inform comms strategies, help clinicians to target hard to reach populations and support UHD to review and adapt its recovery plans and approaches to respond to health inequalities. A dataset will be

Escalation Report

Mar-21

Trauma Orthopaedics -67% 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

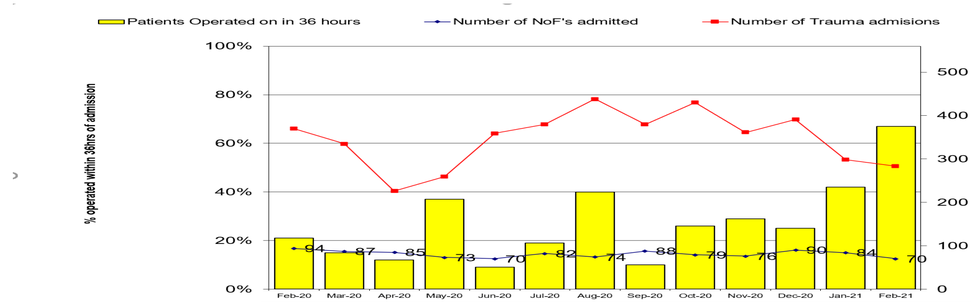
NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
March 2021 Compliance: 63%

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)
March 2021 Compliance: 82%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
March 2021 Compliance: 99%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	4
Patients on anti coagulants	9
Other NoF patients prioritised	7
Loss of weekend capacity due to theatre staffing	0
Awaiting x-ray/scan availability	0
Required medical review pre-op	0
Patient refused surgery	0
Emergency cases prioritised	4
Awaiting specialist surgeon	1
Total breached NoFs	25

Demand on Trauma Directorate during March 2021



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Patients Operated on in 36 hours	21%	15%	12%	37%	9%	19%	40%	10%	26%	29%	25%	42%	67%
Number of NoF's admitted	94	87	85	73	70	82	74	88	79	76	90	84	70
Number of Trauma admisions	370	335	226	259	359	380	438	380	430	361	391	298	283

Escalation Activity in March 2021

Trauma admissions are slowly increasing with 351(298 in Feb) admissions this month, including 70 patients with # NOF. We operated on 67 of the 70 as 2 were for a trial of mobilisation and 1 passed away pre op. A slight reduction in our figures this month, mostly due to the volume of NOF's admitted in a short time period (i.e. 12 in 3 days), and emergency / surgeon specific cases prioritised though most went within 48 hours of admission.
As the month progressed theatres were trying to get back to our pre Covid capacity, though we lost 24 sessions due to lack of theatre staff and some lists could not be utilised due to lack of radiology provision, though this looks to be improving for April as radiology continue to be under staffing pressures.
The 3 lists Saturday and Sunday are the most positive resource to come out of the covid situation for trauma.

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.

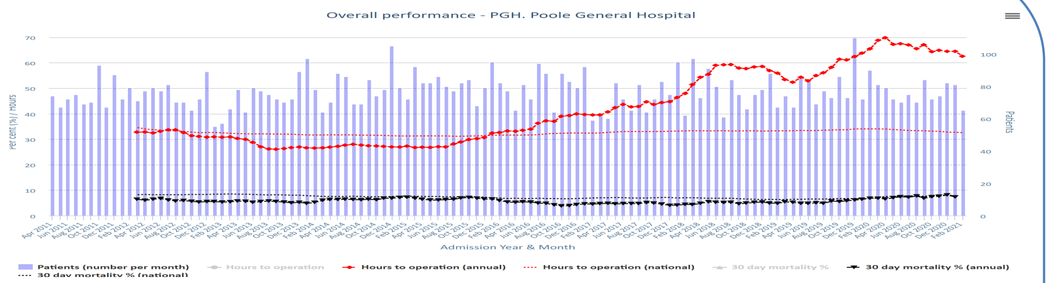
Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	18
Additional theatre slots required	19
Complex Surgery	No. of pts
Total Hip Replacements for NoFs	1
Revisions carried out	0

18 patients required 2 or more trips to theatre, equating to an additional 19 theatre visits, which is approximately 6 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

A number of patients who breached their 36 hours were delayed due to DOACs, as yet we have not yet had the go ahead for the new guidelines for these patients whereby they will hopefully be able to have surgery 24 hours after their last dose rather than 48 hours as it presently stands.
Five patients had a THR for their # NoF in March, 1 who unfortunately was admitted on a Friday and had to wait until Monday for her surgery.

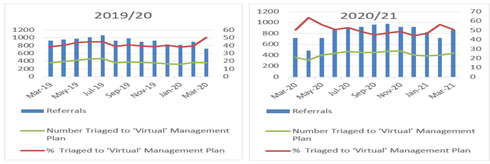
Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	921	21.7	8.2	81.6	52.9	18.3	24.4	97.7	26.4	49.0	88.5
Queen Elizabeth Hospital, Edgbaston	QEB	867	59.0	99.8	71.9	0.0	23.2	0.0	57.7	19.6	56.1	87.8
Norfolk and Norwich Hospital	NOR	842	71.6	66.3	71.3	0.0	28.9	0.0	99.1	14.2	72.6	92.3
Leicester Royal Infirmary	LER	821	64.8	68.2	23.3	79.5	77.5	55.7	98.7	19.8	81.7	90.6
University Hospital of North Staffordshire	STO	763	65.7	51.1	84.9	27.1	21.8	15.7	85.8	38.2	79.1	92.2

March Update on virtual fracture clinic

	2019/20				2020/21			
Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Mar-20	716	50.4	361
Apr-19	953	40.6	387	Apr-20	484	63.6	308
May-19	972	43.7	425	May-20	716	55.9	400
Jun-19	1012	44.6	451	Jun-20	861	50.8	438
Jul-19	1064	44.6	467	Jul-20	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
Jan-20	822	38.2	314	Jan-21	823	46.6	383
Feb-20	899	39.4	365	Feb-21	716	55.9	400
Mar-20	716	50.4	361	Mar-21	861	50.8	438



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 3 months (net gain of 4 residing patients). The number of admissions in March returned to a similar level to those observed in Q2 of 2020/21.

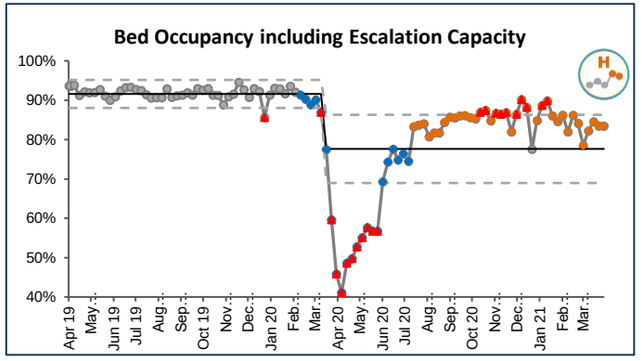
The number of beds consumed by patients with a length of stay greater than 7 days has seen further improvement. An average of 347 beds a day were consumed in March compared to 383 in February (and compared to 398 in March 2020). Bed consumption by patients with a length of stay of over 21 days continues to improve. An average of 105 beds a day were consumed in March compared to 127 in February (and compared to 144 in March 2020).

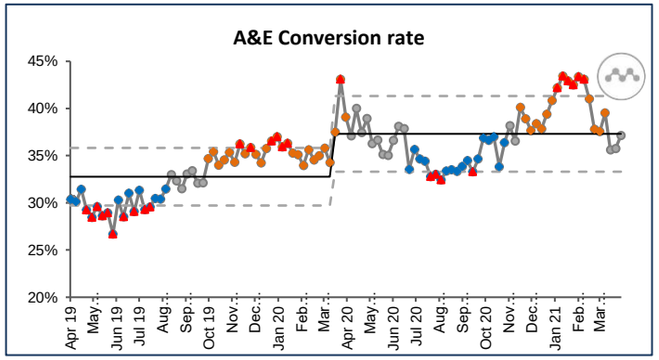
The stabilised discharge to admission ratio and improvement in length of stay metrics is reflected in a favourable occupancy rate of 82.3% in March (84.6% in February), and this remains significantly below the occupancy rates observed in the winter months last year (consistently above 90%). It should be noted however, that a lower occupancy is required to manage covid/non covid pathway flow and cohorting through the admission units and wards.

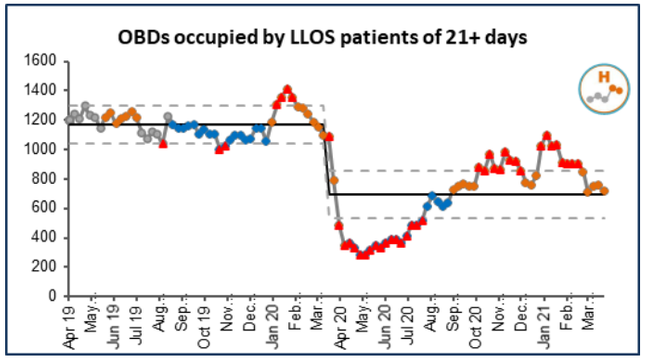
High level Board Performance Indicators & Benchmarking

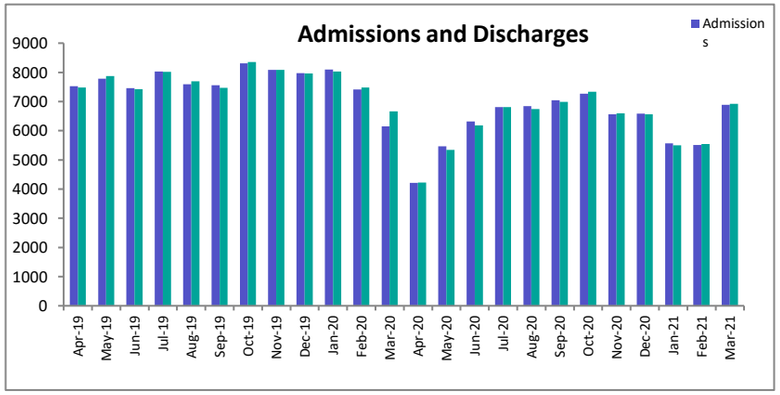
March 2021	**Standard**		**Merged Trust**
Patient Flow			
Bed Occupancy	85%		82.3%
Stranded patients:			
Length of stay 7 days		*42%*	347
Length of stay 14 days		*21%*	184
Length of stay 21 days	108	*12%*	105
Non-elective admissions			6,130
> 1 day non-elective admissions			3,737
Same Day Emergency Care (SDEC)			2,387
Conversion rate (admitted from ED)	30%		37.0%

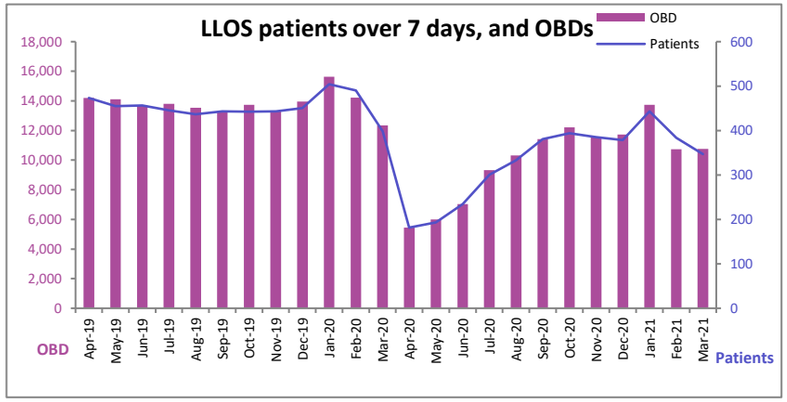
High Level Trust Performance (weekly)











Exception Report

March 21

OCCUPANCY

What is driving occupancy?

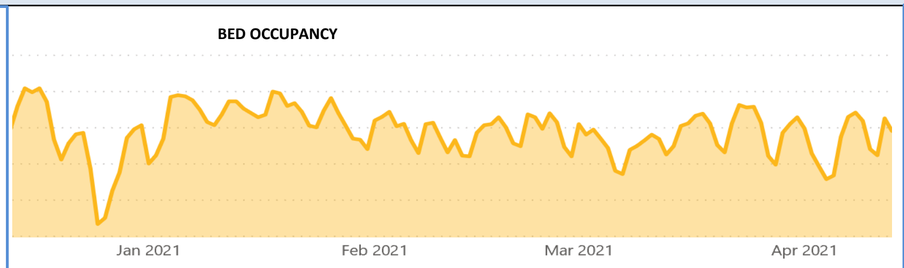
The number of discharges versus the number of admissions have broadly been in balance for the last 3 months (net gain of 4 residing patients). The number of admissions in March returned to a similar level to those observed in Q2 of 2020/21.

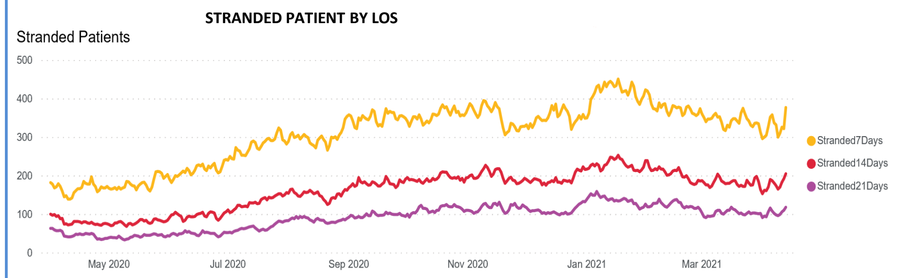
The number of beds consumed by patients with a length of stay greater than 7 days has seen further improvement. An average of 347 beds a day were consumed in March compared to 383 in February (and compared to 398 in March 2020). Bed consumption by patients with a length of stay of over 21 days continues to improve. An average of 105 beds a day were consumed in March compared to 127 in February (and compared to 144 in March 2020).
The stabilised discharge to admission ratio and improvement in length of stay metrics is reflected in a favourable occupancy rate of 82.3% in March (84.6% in February), and this remains significantly below the occupancy rates observed in the winter months last year (consistently above 90%). It should be noted however, that a lower occupancy is required to manage covid/non covid pathway flow and cohorting through the admission units and wards.

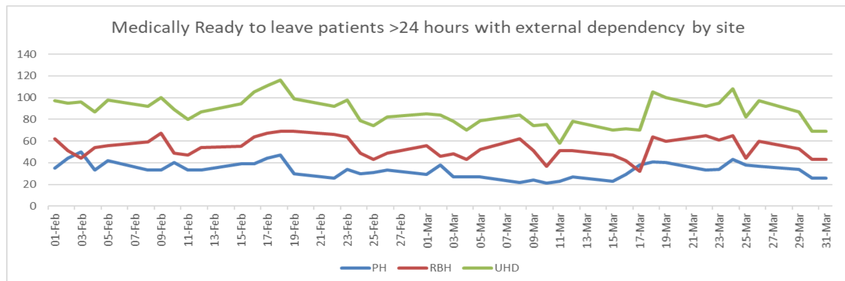
Work underway to define the triggers driving exception reporting around occupancy and the number of patients no longer meeting the Critieria to Reside (C2R)

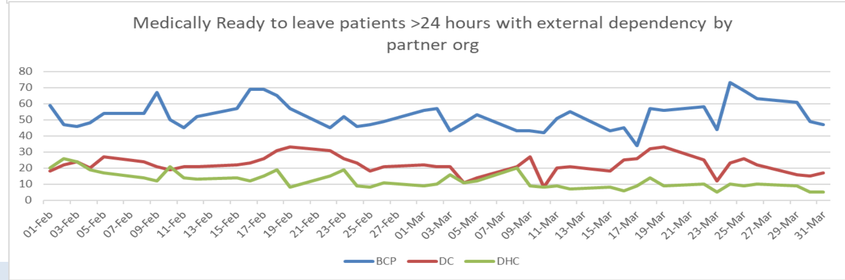
Challenges
- Single Point of Access to support D2A and Home First offer from the acutes requires "localised" approach through Cluster teams who are operationally responsible for "pulling" patients from hospital – this is currently being developed through the "quick wins" workstream of the Home First Design and Delivery Group.
- The number of patients who no longer meet criteria to reside and ready to leave across UHD remains high for patients who require community service provision from Pathway 1.
- End of Life pathways are challenged by a lack of capacity. Marie Curie was commissioned to provide additional support from December, however ongoing integration for the operational management arrangements within Home First Clusters is being developed. This is being driven through the 100 day system plan.
- Large care packages are difficult to source. Mitigation is through step-down to a community hospital bed. Further work required by cluster teams to assess within 24 hours post discharge to reduce demand of large packages.
- Social admissions are still occurring as demonstrated by ward reviews and long length of stay reviews. Social Worker presence across and support to assessment areas is being implemented through the quick wins workstream and step-up pathway to Community Hospitals is being finalised.
- Home First Board with Executive sponsorship and leadership continues to oversee the implementation of D2A.
- Bronze system command remains in place to ensure system wide focus on the 'here and now,' actions needed to reduce occupancy, including the Criteria to Reside Risk Assessment & Action Plan owned by all partner organisations across the Dorset ICS
- Internal Criteria to Reside programme delivered through the weekly Implementation group with oversight from the UEC Quality & Performance Improvement Programme and Operational Performance Group. Results of Criteria to Reside, Phase 1 being finalised to inform phase 2 plan e.g. sustainability and Trust-wide roll out of Criteria to Reside with accountability to be held within Care Groups using a Quality Metric framework.

Delivery
- The System D2A delivery group reports to the Home First board with its function being to design and implement the future D2A model and to trouble shoot the current operational challenges The Board has 5 work streams chaired by members of the delivery group and will support the recommendations of the John Bolton Strategic design of D2A & Home First for Dorset.
- System wide Bronze team assembled in response to winter pressures charged with the delivery of a system wide plan to reduce bed occupancy with oversight from Silver Command. This is aligned to the actions agreed in response to the risk submitted by UHD relating to patients unable to be discharged and the potential for harm and the potential impact to the recovery programme.
- System wide D2A reporting and improvement trajectory in place to inform Bronze group and the actions









Actions Taken

Improvement Actions – Q1 21/22
Dorset wide action plan in place to reduce occupancy across acute and community beds , which has incorporated all agreed actions in response to the risk assessment agreed by the system. This risk has now been added to the system risk register. In addition the Dorset system in partnership with NHSe/i has developed a 100 day plan to drive actions underpinning improvements around discharge.

D2A 'Home First' Model - Internal
- The Criteria to Reside (C2R) Pilot involving 7 wards across UHD, is in the final stages. Data completeness has improved with c30% of patients having incomplete data as compared to 83% reported in Feb 21. This improved data quality has enabled more targeted actions to address delays.
- Internal Criteria to Reside focused programme delivered through the weekly Implementation group with oversight from the UEC Quality & Performance Improvement Programme and Operational Performance Group.
- Discharge Team weekend cover in place across UHD to support additional complex discharges on D2A pathways via community services. There is a sustained improvement in weekend discharge rates helping to support flow and UEC standards.
- Criteria Led Discharge pilot undertaken across two Older Persons ward areas using a draft Standard Operating Procedure.
- Reviewing and revising the trigger and threshold for exception reporting around occupancy and patients who no longer meet C2R.

System Support
- NHSE/I - 100 Day Improvement Plan supported by all partner organisations across Dorset ICS to reduce number of patients who no longer meet criteria to reside. Existing Risk Assessment Action plan has been incorporated into the 100 day improvement plan.
- National extension of funding support to facilitate discharge from hospital, in place until September 21.
- Improved flow through community beds - plans being progressed to step down all patients from acutes who require a pathway 2 option, to avoid inappropriate use of care home beds .
- Personal Health Commissioning Team (PHC) operational policy being developed to support complex patients on P3 & P1 pathways.
- A review of all pathway 1 services is being undertaken with a view to free up capacity to support acute and community transfers. This bringing together of services will reduce complexity and more effectively meet demand as services are 'pooled.'
- Cluster Team review to provide localised operational improvements across acute hospital and interfacing community services to reduce the number of patients who do not meet criteria to reside.
- Dr John Bolton continues to work with Dorset in establishing a more effective discharge model, including the commissioning needed to underpin a 'home first' model, focusing on use of community hospital beds as a transition whilst services for Pathway 1 are re-commissioned to improve the Home First offer. Programme currently in diagnostic phase with UHD supporting with a number of data collection requests around discharge.
- Focussed complex patient review was undertaken as part of the Easter readiness plan. The reviews resulted in a reduction in > 21 day LLOS patients and contributed to a drop in occupancy in preparation for the 4 day break.

Lead Director Mark Mould

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- DNA rates have stabilised and achieved the 5% standard however patient cancellation rates remain high
- Increasing Covid Tier restrictions and lockdown since December has resulted in increased DNAs and patients not wanting to attend for F2F OPAs and Diagnostics.
- Detailed validation programme is underway over the next 6 months in order to validate the outpatient waiting list, including new and follow up appointments.

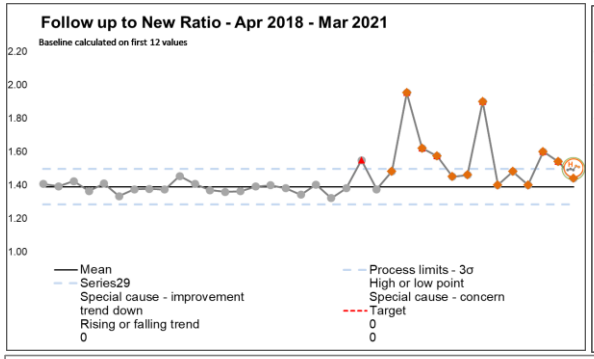
Diagnostics

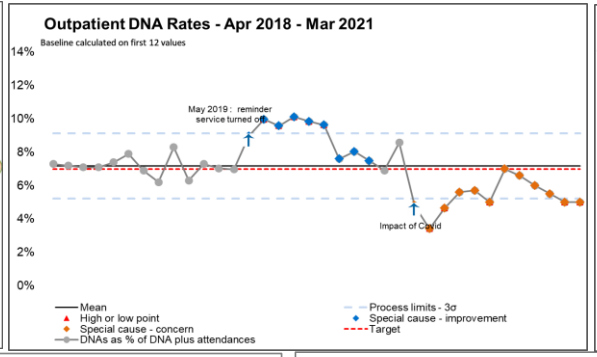
- Increased well from 94.1% to **97.1%** of all diagnostics tests were achieved within the required 6 weeks
- Radiology has contiued to achieve at 99.2% with support from ISPs, additonal weeekend sessions and WLIs
- Endoscopy has significantly improved from 72.5% in February to 89.2%, work is ongoing to consolidate the endoscopy IT systems - moving to single waiting list
- Echocardiography recovery plan is constrained by availability of insourcing solution, however this has improved slightly from 92.2% to 93.1%
- Neurophysiology has improved to 98.9%
- Urodynamics has achieved at 100%.

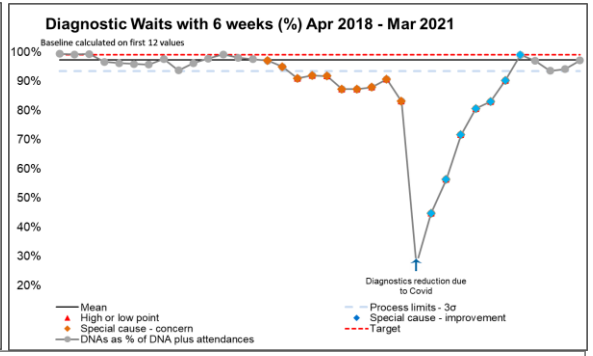
High level Board Performance Indicators & Benchmarking

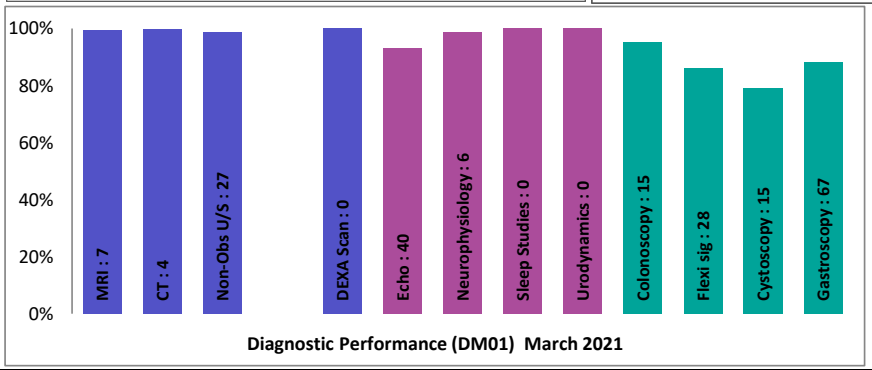
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 19/20 v 20/21)*	-0.5%	126000 / 97770	-22.4%
Total Referrals Rate year on year +/-		-0.5%	217804 / 180370	-17.2%
Outpatient metrics				
Overdue Follow up Appts				15,669
Follow-Up Ratio		1.91		1.44
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	33665 / 1785	5.0%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		33665 / 1917	5.4%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*		33665 / 14324	42.5%
Diagnostic Performance (DM01)				
% of <6 week performance	*(Total / 6+ Weeks)*	1%	7313 / 209	2.9%

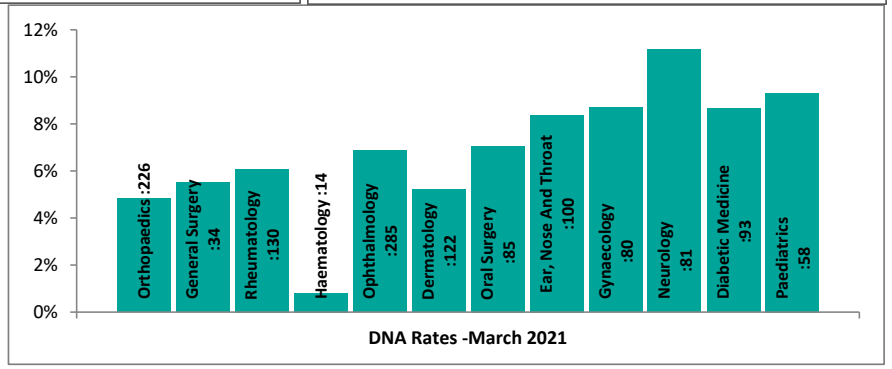
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on high level board position

Bowel Screening
Invitation Backlog Recovery:
During the first wave of the Covid pandemic, the inviting of bowel screening subjects to complete home testing kits was paused from April to July 2020. As a result a backlog of subjects has accumulated. At its peak the total number of subjects delayed an invitation or invited not screened was 43,693 in October of 2020. The aspiration of Commissioners and the Programme is to return to normal inviting (first invitation is sent two weeks after a subject reaches their 60th birthday and then two years after their last episode closes) as soon as possible. In October 2020 and January 2021, the weekly invitation rate was increased further above pre Covid inviting to support this. The programme will be back to normal inviting week commencing 10th May 2021. The backlog is steadily reducing and as of this month there are 30,997 subjects remaining. At this time the programme is meeting key performance standards, but the context of the backlog recovery needs to be taken into consideration.
SSP Clinic Wait Standard (*The proportion of patients with an abnormal FIT result offered an appointment with a Specialist Screening Practitioner (SSP) within 14 days of referral):* The clinic wait standard has been maintained at 100% (acceptable performance = 95%; achievable performance = 98%) for the last year via virtual clinics.
Diagnostic Wait Standard *(The proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)***:** The diagnostic wait standard has been above 90% since August 2020 (acceptable performance = 90%; achievable performance = 95%). This is the key standard at risk if the programme has an influx of screening subjects returning their FIT kits. However, there is additional capacity available via the PHE funded insourcing weekends at Poole site and weekend lists in the mobile unit at the Bournemouth site.

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

Recovery is planned to accommodate the installation of new equipment in DBSU and resulting reduction of screening capacity during this period. One of the three original vans has been located at RBH to support the symptomatic service whilst RBH equipment is replaced. The newly acquired van will undertake screening at the Bournemouth site from April 26th for the bournemouth conurbation practices.

Additonal mammography screening equipmment has been purchased and is in storage pending the identification of a location , which is in progress.

Appointment times have bee reduced to 7.5 minutes in line with other screening units.This is an increase of approximately 30% per day which further improves throughput.
A business case has been submitted for both breast radiologists and mammographers , the recruitment to these posts will support the recovery trajectory.

Recovery **could** be achieved by March 2022 (PHE target date). This is dependent on investment, extra staffing and no further peaks of Covid. The current plan commenced on April 1st to achieve the target however, without additional staffing the recovery will be delayed.

High level Board Performance Indicators & Benchmarking

Bowel Screening	Standard	Trust
SSP Clinic Wait Standard (14 days)	95% (98% Best Practice)	**100%**
Diagnostic Wait Standard (14 days)	90% (95% Best Practice)	**90%**

Breast Screening	Standard	Trust
Screening to normal results in 14 days	95%	**99%**
Screening to first offered assessment appointment in 3 weeks	98%	**100%**
Round Length within 36 months	90%	**12.50%**
Longest wait time	36 months	**45 months**

Screening Programmes

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

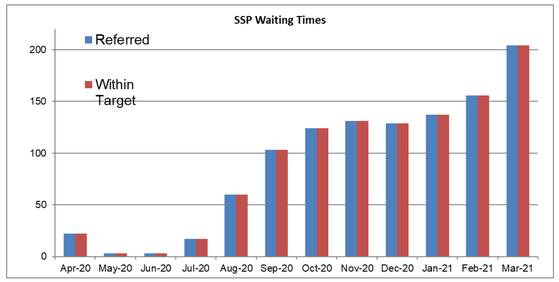
Bowel Screening
At this time the programme is meeting key performance indicators, however, there remains a significant backlog of screening subjects delayed an invitation and invited not screened. due to the initial pause at the start of the Covid pandemic. The programme has laid out an ambitious recovery programme to address this backlog, with agreement from PHE, and the current weeklyinvitation rate has been increased to 3231 as of end of January 2021 against a pre Covid invitation rate of 1894. The overall number of patients waiting dropped by 5949 in April 2021 compare d to March as a result of this .

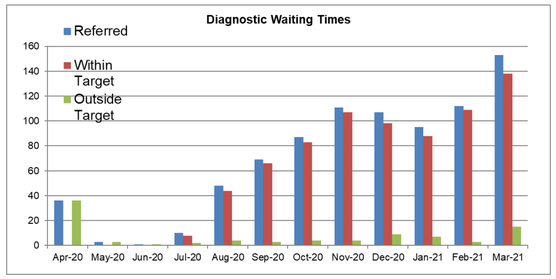
Based on the PHE recovery modelling tool the programme expects to return to normal inviting (0 weeks) week commencing 10th May.

The programme is now experiencing the impact of the increased invitation rate with significantly higher numbers of screening subjects attending SSP clinics. There was more than a 30% increase in numbers in clinic inMarch compared to February 2021.

The programme has additional capacity ready to use as required via the mobile unit on the Bournemouth site and PHE funded insourcing weekends. at the Poole site.

Bowel Supporting Data Here



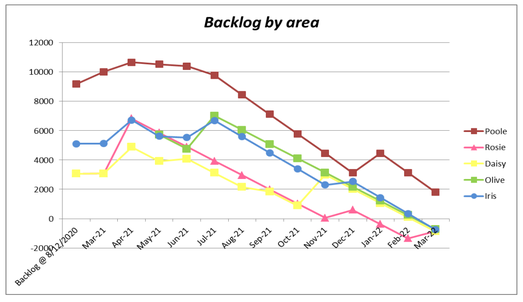


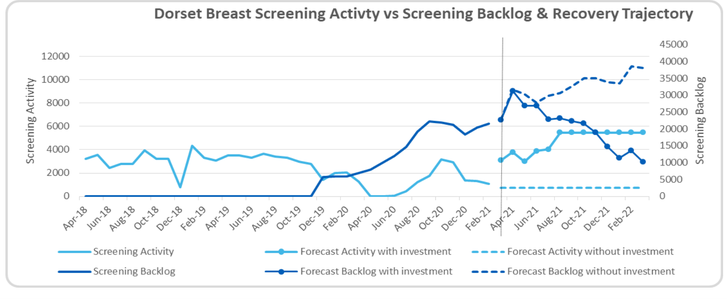
Month	Invited but not screened	Delayed an invitation
Aug-20	5567	21354
Sep-20	5140	28102
Oct-20	11226	32467
Nov-20	12411	29908
Dec-20	15145	26925
Jan-21	15172	25853
Feb-21	15620	24603
Mar-21	17431	19515
Apr-21	17532	13465

Actions Taken to Date:
* Scopedthe backlog of patients who were paused during the first wave of the Covid pandemic (98% scoped by the end of July 2020)
* Scoped the backlog of surveillance patients pasued during the first wave of the Covid pandemic (85% scoped by the end of August 2020)
* Restarted weekly invitations in August 2020 at a lower rate than pre Covid
* Increased the invitation rate to above the pre Covid level in October 2020 (2394 against a rate of 1894)
* Increased the invitation rate again to 3231 as of end of January 2021
* Delivered additional WLI lists with bowel scope underspend (2020/21)
* Delivered two weekends of insourced activity in March 2021 with bowel scope underspend (2020-21)
* Delivered one weekend of insourced activity in April 2021 with PHE funding

Ongoing Actions to Support Recovery:
* Maintaining increased invitation rate until backlog recovered to 0 weeks
* Insourcing weekends funded by PHE in Q1 & Q2
* Additional weekend lists in the mobile unit in May and June
* Managing the bowel scope cohort invited then paused in 2020 in Q1 (c.900 subjects)

Breast Screening
A new modelling tool has been created and is being utilised to calculate recovery.
Recovery has been planned around installation of new equipment in DBSU and subsequent loss of screening availability during the works.
Olive van is being seconded to RBH to support the symptomatic service whilst RBH mammography equipment is replaced.
Purchased Plymouth van will be used to screen Bournemouth round from 15th April.
The team have taken a bold decision to reduce appointment times to 7.5 minutes as a trial to achieve the target date. This is in line with the lowest time in the region and will put us above pre COVID capacity. This is essential if we are to recover in the region of March 2022.
4th mammography screening kit has been ordered and we will have the use of the Plymouth van until a site for the 4th mammography kit is found (discussions on-going).





Ongoing actions include:
We are currently screening 1 Saturday a month where staffing allows. Evening clinics have been reintroduced as of 1st March twice weekly – staffed with standard working hours.
Fortnightly restoration/monitoring meetings with PHE offering support and updates from the national perspective are still on-going.
Weekly department management meetings are still on-going.
Utilisation of PHE modelling tool is updated each time we increase/reduce screening.
A business case has been put in for 3 breast radiologists, we are still awaiting the decision.
DBSU has joined a regional international recruitment process, with interviews planned.
Recovery ***could*** be achieved by March 2022 (the PHE target.)
This is dependent on investment, extra staffing and no further peaks of COVID. The current plan starts April 1st to get to the target. With every months delay the recovery will be pushed back.

FINANCE

Commentary

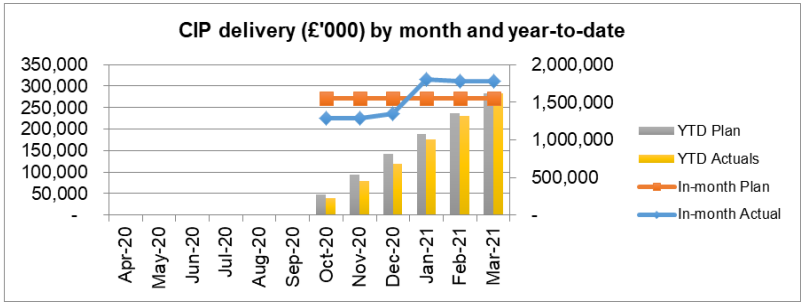
Consistent with the national interim financial framework the Trust set a planned deficit of £5.6 million for the period to 31 March 2021, inclusive of ongoing COVID-19 costs, recovery of elective services and winter preparedness.

Against this plan, for the six-months ending 31 March 2021, the Trust has delivered a favourable variance of £5.7 million reporting an aggregate surplus of £145,000. This variance resulted from lower than planned expenditure in relation to ongoing COVID-19 costs, winter preparedness and the recovery of elective services; together with additional income to off-set the continued reduction in non-NHS income (£3.3 million) and reimburse independent sector costs for elective activity (£2 million). Within this position, cost improvement savings of £1.6 million have been delivered consistent with the budgetary target.

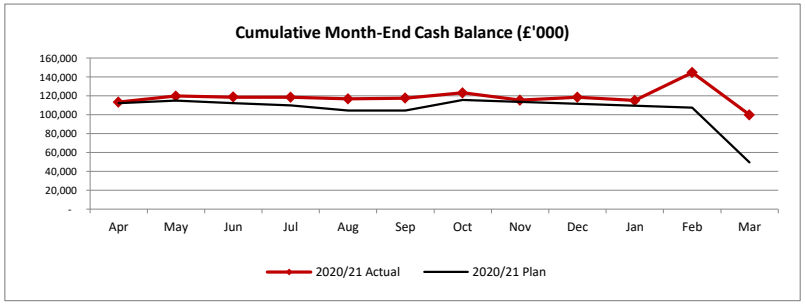
As at 31 March 2021 the Trust has delivered a £5.131 million capital underspend as part of the overall ICS capital envelope. Furthermore, the Trust agreed not to draw STP Wave 1 Capital funding of £7.122 million which will be available next year.

The Trust is currently holding a consolidated cash balance of £99.7 million at 31 March 2021. Although the current cash position is strong, this is fully committed against the Trusts 6 year capital program and thus the cash position continues to be monitored closely.

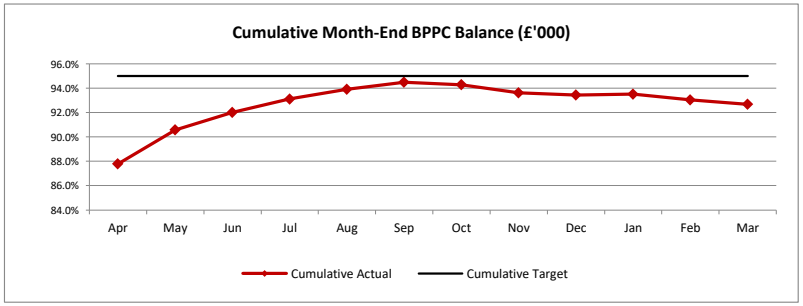
FINANCIAL INDICATORS	Year to date			Forecast
	Budget *£'000*	Actual *£'000*	Variance *£'000*	Variance *£'000*
Control Total Surplus/ (Deficit)	(5,558)	145	5,703	5,703
Capital Programme	76,023	70,893	5,131	5,131
Closing Cash Balance	49,318	99,724	50,406	50,406
Public Sector Payment Policy	95%	93%	-2%	-2%



REVENUE	Year to date		
	Budget *£'000*	Actual *£'000*	Variance *£'000*
Surgical	(67,866)	(67,396)	470
Medical	(89,141)	(88,898)	243
Specialties	(77,092)	(75,501)	1,592
Operations	(11,659)	(12,046)	(387)
Corporate	(33,352)	(34,564)	(1,212)
Trust-wide	273,510	279,628	6,118
Surplus/ (Deficit)	(5,600)	1,224	6,824
Consolidated Entities	0	229	229
Surplus/ (Deficit) after consolidation	(5,600)	1,453	7,053
Other Adjustments	42	(1,308)	(1,350)
Control Total Surplus/ (Deficit)	(5,558)	145	5,703



CAPITAL	Year to date		
	Budget *£'000*	Actual *£'000*	Variance *£'000*
Estates	7,539	7,764	(225)
IT	10,313	10,367	(54)
Medical Equipment	9,665	10,047	(382)
Covid-19	1,581	1,581	(0)
Strategic Capital	46,924	41,134	5,791
Total	76,023	70,893	5,131



University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 April 2021

Agenda item: 6.1

Subject:	Lead Governor and Deputy Lead Governor

Prepared by:	Company Secretary
Presented by:	Chairman

Purpose of paper:	To update the Council of Governors on the results of the voting for the Lead Governor and the Deputy Lead Governor
Background:	University Hospitals Dorset NHS Foundation 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.
Key points for the Council of Governors:	The Council of Governors previously agreed the process to appoint the Lead Governor and the Deputy Lead Governor. Three governors self-nominated themselves for the role of Lead Governor. 19 members of the Council of Governors voted as follows: • David Triplow 8 • Sharon Collett 6 • Michele Whitehurst 5 David Triplow is therefore nominated as the Lead Governor and Sharon Collett is nominated as the Deputy Lead Governor.
Options and decisions required:	Following the process previously agreed by the Council of Governors, approve the appointment of the Lead Governor and Deputy Lead Governor for one year terms.
Recommendations:	Approve David Triplow as the Lead Governor for one year. Approve Sharon Collett as the Deputy Lead Governor for one year.
Next steps:	Communicate the appointments

	Regular meetings between the Chairman and the Lead Governor & Deputy Lead Governor

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**

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 April 2021

Agenda item: 6.2

Subject:	The Membership and Engagement Group Terms of Reference

Prepared by:	Zoe Jones
Presented by:	Sue Parsons

Purpose of paper:	To review the Terms of Reference of the Membership and Engagement Group for the Council of Governors of University Hospitals Dorset NHS Foundation Trust.
Background:	The Terms of Reference were reviewed by the Membership and Engagement Group on the 10 March 2021.
Key points for the Council of Governors:	The key points are: • The Group will facilitate and develop membership engagement, recruitment and retention. • The Group will receive and discuss membership reports on recruitment, engagement and development. • The Group will provide oversight to the delivery of the Membership Strategy and review the strategy and action plan as appropriate. • The Group will receive updates on the Membership Strategy objectives and delivery of the Action plan at each meeting. • The Group will receive reports from each of the public constituencies. • The Group will work with the Council of Governors especially the publicly elected members to engage with and grow the public membership. • The position of chairman and deputy chairman will be reviewed after an initial two years and subsequently at least every two years • The meeting is open to all Governors but only members of the Group may vote. • The meeting will be open to a member of the UHD Patient Experience Team. • The Group will meet a minimum of four times per year.
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 shared drive

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**
Membership and Engagement Group	10 March 2021

TERMS OF REFERENCE

for

The Council of Governors Informal:

Membership and Engagement Group

DOCUMENT DETAILS

Author:	Carrie Stone
Job Title:	Company Secretary
Signed:	
Date:	January 2021
Version No:	1
Next Review Date:	January 2023

Approving Body/Committee:	Membership and Engagement and Group
Chair:	TBC
Signed:	
Date Approved:	TBC
Target Audience:	Governors of the Trust

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
January 21	1	January 2023	March 2021	Carrie Stone	New

TABLE OF CONTENTS

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

MEMBERSHIP and ENGAGEMENT GROUP

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Membership and Engagement Group is a forum for discussion on membership engagement, development and recruitment and to oversee and review the Membership Strategy on behalf of the Council of Governors. The Group is an informal group of the Council of Governors of University Hospitals Dorset NHS Foundation Trust.

2. MEMBERSHIP/ATTENDANCE

2.1 Membership of the Group consists of:

- Two Governors from each of the three public constituencies
- One Governor from the staff constituency
- Governor from the appointed constituency – Volunteers Group
- Assistant Company Secretary
- A Non-Executive Director of the Board of Directors
- Associate Director of Communications

2.2 The chairman and deputy chairman of the Group will be two of the publicly elected Governors.

2.3 The term of office for the chairman and deputy chairman will be for a 2 year term with a permitted maximum of 3 x 2 year terms.

2.4 The Group may invite others (this includes internal staff or external partners) any director or employee to attend meetings.

2.5 The meeting is open to all Governors but only members of the Group may vote.

2.6 The meeting will be open to a member of the UHD Patient Experience Team.

3. FREQUENCY OF MEETINGS

3.1 The Group will meet a minimum of four times per year.

4. QUORUM

4.1 At least three members, including the chairman or nominated deputy.

5. RESPONSIBILITIES

5.1 The Group will facilitate and develop membership engagement, recruitment and retention.

5.2 The Group will receive and discuss membership reports on recruitment, engagement and development.

5.3 The Group will provide oversight to the delivery of the Membership Strategy and review the strategy and action plan as appropriate.

5.4 The Group will receive updates on the Membership Strategy objectives and delivery of the Action plan at each meeting.

5.5 The Group will receive reports from each of the public constituencies.

5.6 The Group will work with the Council of Governors especially the publicly elected members to engage with and grow the public membership.

6. COMMUNICATION

6.1 The notes of each meeting of the Group will be formally recorded and submitted to the next Group meeting.

6.2 The Chairman of the Group will report back to the Council of Governors.

6.3 The public constituency representatives will report back to their respective constituencies after each meeting on the outcome of the meeting.

7. REVIEW

7.1 The Terms of Reference of this will be reviewed by the Group no later than three yearly and all amendments will be reported to the Council of Governors.

7.2 The position of chairman and deputy chairman will be reviewed after an initial two years and subsequently at least every two years.

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 29 April 2021

Agenda item: 6.3

Subject:	The Membership and Engagement Group Strategy

Prepared by:	Zoe Jones
Presented by:	Sue Parsons

Purpose of paper:	To review the Membership and Engagement Group Strategy for the Council of Governors of University Hospitals Dorset NHS Foundation Trust.
Background:	The Membership and Engagement Group Strategy 2020-2023 was taken to both Council of Governors meetings in April 2020. Both Membership Engagement Groups discussed the strategy at meetings in July 2020 and most recently at the inaugural UHD Membership and Engagement Group on 10th March 2021. All comments received have been reviewed and where possible included, none of which were material changes to the draft reviewed.
Key points for the Council of Governors:	The key points are: • This strategy outlines our plans for membership development for 2020-2023 following the merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to form University Hospitals Dorset NHS Foundation Trust. • It sets out our vision for engaging with our Foundation Trust members and the communities we serve. We need members to be involved so they can hear first-hand what is going on, they can share their views and thoughts on our plans and they can help influence the development of our hospital services. This will help us improve our services for the benefit of all. • OUR MEMBERSHIP OBJECTIVES 2020-2023 1. To build representative membership that reflects our whole population of Dorset and west Hampshire; 2. To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged; 3. To ensure our staff members have

	opportunities to become more actively engaged as members.
Options and decisions required:	To approve the Membership and Engagement Group Strategy or make further amendments.
Recommendations:	To approve the Membership and Engagement Group Strategy.
Next steps:	To add to the Trust's shared drive

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**
Membership and Engagement Group	10 March 2021

MEMBERSHIP STRATEGY 2020-2023

INTRODUCTION

This strategy outlines our plans for membership development for 2020-2023 following the merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to form University Hospitals Dorset NHS Foundation Trust.

It sets out our vision for engaging with our Foundation Trust members and the communities we serve. We need members to be involved so they can hear first-hand what is going on, they can share their views and thoughts on our plans and they can help influence the development of our hospital services. This will help us improve our services for the benefit of all.

WHY MEMBERSHIP MATTERS

As an NHS Foundation Trust, we are accountable to our patients and the public. Our members have a key role in the Trust's governance; they elect representatives to sit on our Council of Governors, which in turn appoints the Chairman and Non-Executive Directors to the Board of Directors and oversees the Board's performance.

Members include our staff, our patients and members of the public. We believe that involving our members, patients and public in decisions about services is an integral part of meeting the needs of the communities we serve. Membership helps give those communities a voice in the running of the Trust and shaping our plans for the future.

This membership strategy sets out a series of objectives for the Trust to maintain, grow and engage its membership. It also describes how the Trust will evaluate the delivery of the strategy. The strategy will be delivered within the wider framework of Trust strategies, which address the issues and equality and diversity, public, patient and carer involvement, user engagement and communications.

Our vision is to develop an actively engaged and vibrant membership. Over the next three years, as a new organisation, we want to develop how we engage and involve our members, building a more active membership and giving members a voice in shaping how the organisation works. This strategy outlines the measures we will put in place during 2020-23 to achieve that vision.

We have developed this strategy based on the work of the Joint Governor meeting, between RBCH and PHFT, held in November 2019, good practice from other Foundation Trusts and NHS Providers, and statutory and regulatory requirements. The Strategy is supported by an action plan which sets out what we will do in practice across the next three years to achieve our vision.

OUR MEMBERSHIP

Our members include our staff, our patients and people from across the diverse communities we serve both locally and regionally.

Who can be a member?

Public members

The Royal Bournemouth Hospital provides general health care for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of over 550,000. This is a major tourist area and during the summer months over one million holidaymakers visit Bournemouth including substantial numbers of foreign language students. A district-wide strategic review has led to concentration of specialised services within particular provider units. Among the specialties at RBH are: The Dorset Heart Centre; elective orthopaedics; eye unit; cardiology; interventional radiology; stroke services.

Poole Hospital provides a wide range of acute services to people in Poole, east Dorset and Purbeck and serves as the major trauma centre for east Dorset. The hospital was built in 1970 and all the principal specialties are represented providing services for all medical, elderly, surgical and child health emergency admissions to include general surgery, trauma, ENT, oral and maxillofacial surgery, obstetrics, gynaecology, paediatrics, general medicine, neurology, rheumatology and dermatology. As the designated Cancer Centre for Dorset, the Trust provides cancer services for the whole of Dorset.

Following Dorset Clinical Commissioning Group's Clinical Services Review, the Royal Bournemouth Hospital will become the major emergency care hospital for the region and Poole Hospital the major planned care hospital. This will see a significant investment across University Hospitals Dorset NHS Foundation Trust, providing much better facilities for both patients and staff. These developments will be implemented over the next five years.

We offer all those interested in or with a connection to the Trust the opportunity to become a member. Members do not need any special skills or experience. It is free and open to anyone 16 years of age or older. Our public members include patients, volunteers and all other members of the public who wish to become involved. They come from our geographical constituencies of Bournemouth, Christchurch, East Dorset and rest of England and Poole and rest of Dorset. With our combined membership we currently have 15,401public members.

Staff members

We have c9000staff members of the Trust. Any member of staff employed by the Trust on permanent contracts of fixed term contracts of 12 months or longer can become a member. Staff employed through service partners including transport, catering and cleaning staff, also provide valuable services and are also eligible to become members.

Why become a member?

The core benefit of becoming a member is to have a regular voice – to shape the way services are provided, contribute to the future direction of the organisation, and ensure the Trust is responsive to the needs of people and communities it serves. Alongside this, membership provides opportunities to show support for the Trust and its work. In general terms, the benefits of membership include:

- Getting regular and up-to-date information about the Trust

- Invitations to attend free health talks and other events provident updates on Trust activities and the opportunity to speak with hospital representatives on a range of subjects and to attend and ask questions at the Annual Members' Meeting

- Voting for representatives on the Council of Governors and standing for election to the Council of Governors (for those age 16 years of over)

- Taking part in surveys and consultations

- Participating in patient involvement initiatives

- Access to NHS Discounts Scheme

Levels of Membership

We recognise that some members may wish to be more actively involved in the work of the trust than others. Members in each of the trust's constituencies are therefore able to determine the level of engagement that they wish to have in the work of the trust, with one option being to participate in the election of the trust's Council of Governors during the governors' election process.

The trust asks its members to indicate the level of involvement that they wish to have, in order that it can manage its contacts and communications appropriately.

To help members decide their level of involvement, the trust has established three levels of membership:

Level 1 – Informed

Level 1 members are kept informed of new developments and information regarding the trust; they are able to participate in the elections of members to the council of governors and are able to attend and participate in the annual members' meeting.

Level 2 – Involved

In addition to the benefits of Level 1 membership, Level 2 members participate in a range of activities such as surveys, focus groups and special interest events.

Level 3 – Active

In addition to Level 1 and 2 benefits this level includes those members who have a more active role in the trust, either as an elected governor on the council of governors and / or who actively participate in the work of the trust in another way (including helping in service development meetings, compliance audits, staff interviews, attending board meetings and increasing their knowledge and skills in specific areas of interest).

Members may change their membership level at any time by contacting the trust's membership office.

Representing the interests of members

Members' views and opinions are heard through the Council of Governors, whose role is to represent the interests of members and hold the Board to account through the Non-Executive Directors. The Council of Governors is made up of 17 elected public members, five elected staff Governors and 5 appointed Governors from stakeholder organisations. All public members aged 16 or over are allowed to stand as a Governor or vote for a Governor. All staff members are able to stand as a Governor or vote for a Governor within their staff constituency.

The Council of Governors is responsible for:

- Representing the interests of members and the public
- Appointing the Chairman and other Non-Executive Directors, and holding them to account for the performance of the Board
- Approving the appointment of the Chief Executive by the Non-Executive Directors
- Receiving the Trust's Annual Report and Accounts
- Appointing the Trust's external auditors
- Being independent ambassadors of the Trust

The Trust is committed to developing and supporting Governors to enable them to carry out their role and contribute fully to the work of the Council of Governors. Our Governors attend Board meetings and Committees of the Board, giving our Governors broader access. Further details of the composition of the Council of Governors is set out in Appendix 1.

OUR MEMBERSHIP OBJECTIVES 2020-2023

Our vision is to build on our engagement with our members in order to create an active and vibrant membership community, one that is representative of the diverse population we serve and of the staff who work here, and one that has a real voice in shaping the future of the Trust and the services it provides. To achieve this vision our strategy sets out three overarching aims:

1. To build representative membership that reflects our whole population of Dorset and west Hampshire;
2. To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged;
3. To ensure our staff members have opportunities to become more actively engaged as members.

Delivering these aims is intended to support University Hospitals Dorset NHS Foundation Trust (UHD) in meeting its objectives, not least through being a responsive organisation with a good understanding of the needs of its patients and the communities it serves.

Objective 1: To build representative membership that reflects our whole population of Dorset and west Hampshire.

To achieve this we will:

- Maintain an accurate membership database and analyse our membership on a regular basis
- Develop targeted campaigns to recruit members from any group which is under-represented
- Promote membership opportunities to younger people in our communities
- Refresh the membership pages on the Trust's website
- Articulate clearly the benefits of membership
- Refresh our membership recruitment material
- Work more innovatively with our partners to promote membership

Objective 2: To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged

To achieve this we will:

- Promote the work of the Trust's governors, as representatives of our members
- Develop new opportunities for members to express their views
- Introduce new types of membership so members can choose how involved they want to be
- Refresh our existing ways of communicating with members and our approach to membership communication and engagement.
- Develop our programme of engagement events

Objective 3: To ensure our staff members have opportunities to become more actively engaged as members

To achieve this we will:

- Increase support to staff governors
- Develop a plan to increase awareness of staff governors through staff induction and other training events
- Promote the value of such a role to the benefit of both individual, their department and the constituency they represent

Delivering the strategy and evaluating success

Through this strategy, we want to achieve a step change in how we engage with members. To achieve this, we need to implement and deliver the strategy effectively. As an organisation committed to learning, we recognise the importance of measuring its impact and evaluating its success.

Implementation

We have developed an action plan which sets out the practical steps we will take in each year to implement the strategy.

Evaluating success

The Council of Governors is responsible for the delivery of the strategy, it will be supported by the Governors' Membership and Engagement Group which will report regularly to the Council of Governors.

The Governors' Membership and Engagement Group will directly oversee the Trust's efforts to engage with all of its members. It will receive updates at each meeting on the delivery of the strategy.

Appendix 1
Composition of the Council of Governors by Constituency

Public Constituencies	Number of governors
Bournemouth	6
Christchurch, East Dorset and Rest of England	5
Poole and Rest of Dorset	6

Staff Constituencies	Number of governors
Medical & Dental	1
Allied Health Professionals, Scientific & Technical	1
Nursing, Midwifery & Healthcare Assistants	1
Administration, Clerical & Management	1
Estates and Ancillary Services	1

Appointed Governors - Stakeholder organisations	Number of governors
NHS Dorset CCG	1
Dorset Council	1
Bournemouth, Christchurch and Poole Council	1
NHS Foundation Trust Volunteers Group	1
Bournemouth University	1

Membership Constituencies

Members currently fall into constituencies: Public and Staff. The following table includes a description of each constituency, the minimum membership required (as stated in the Constitution), the current number of members and the number of seats for the constituency on the Council of Governors:

Name of Constituency	For the residents of:	Minimum number of members	Members at 1 April 2021	Seats on the Council of Governors
Public	**Bournemouth** The following electoral wards: • Boscombe East & Pokesdown • Boscombe West • Bournemouth Central • East Cliff & Springbourne • East Southbourne & Tuckton • Kinson • Littledown & Iford • Moordown • Muscliff & Strouden Park • Queen's Park • Redhill & Northbourne • Talbot & Branksome Woods • Wallisdown & Winton West • West Southbourne • Westbourne & West Cliff • Winton East	50	6017	6
	Christchurch, East Dorset and Rest of England The following electoral wards and all electoral wards in the rest of England not included in any other	50	3539	5

Name of Constituency	For the residents of:	Minimum number of members	Members at 1 April 2021	Seats on the Council of Governors
	Area for the Public Constituency set out in this table: • Burton & Grange • Christchurch Town • Commons • Highcliffe & Walkford • Mudeford, Stanpit & West Highcliffe • Colehill & Wimborne Minster East • Corfe Mullen • Cranborne & Alderholt • Cranborne Chase • Ferndown North • Ferndown South • St Leonards & St Ives • Stour & Allen Vale • Verwood • West Moors & Three Legged Cross • West Parley • Wimbourne			
	Poole and Rest of Dorset The following electoral wards: • Alderney & Bourne Valley • Bearwood & Merley • Broadstone • Canford Cliffs • Canford Heath • Creekmoor • Hamworthy • Newtown & Heatherlands • Oakdale • Parkstone • Penn Hill • Poole Town • Beacon • Beaminster • Blackmore Vale • Blandford • Bridport • Chalk Valleys • Charminster St Mary's • Chesil Bank • Chickerell • Crossways • Dorchester East • Dorchester Poundbury • Dorchester West • Eggardon • Gillingham • Hill Forts & Upper Tarrants • Littlemoor & Preston	50	5845	6

Name of Constituency	For the residents of:	Minimum number of members	Members at 1 April 2021	Seats on the Council of Governors
	• Lyme & Charmouth • Lytchett Matravers & Upton • Marshwood Vale • Melcombe Regis • Portland • Puddletown & Lower Winterborne • Radipole • Rodwell & Wyke • Shaftesbury Town • Sherborne East • Sherborne Rural • Sherborne West • South East Purbeck • Stalbridge & Marnhull • Sturminster Newton • Swanage • Upwey & Broadwey • Wareham • Westham • West Purbeck • Winterbourne and Broadmayne • Winterbourne North • Yetminster			
Staff	• Medical & Dental • Allied Health Professionals, Scientific & Technical • Nursing, Midwifery & Allied Healthcare Professionals • Administration, Clerical & Management • Estates & Ancillary Services	4 4 4 4 4	c9000	5
Totals		170		22

Appendix 2
Membership Strategy Action Plan

The following action plan sets out how the vision and objectives set out in our Membership Strategy 2020-2023 will be implemented in practice:

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
Objective 1: To build a representative membership that reflects our whole population of Dorset and West Hampshire	Maintain an accurate membership database and analyse our membership on a regular basis	• Ongoing monitoring and management of the membership database	• As year 1	As year 1
	Develop targeted campaigns to recruit members from any group which is under represented	• Develop proposals for engaging with groups that are less well represented within the Trust's membership, in particular the age group age 16+. Engage with other Trusts to understand how they have approached engagement with these groups and use this to inform the development of tailored engagement plans. • Introduce membership recruitment stand at Bournemouth University freshers' fair.	• Subject to learning from year 1 activities, roll out comprehensive plans for engagement with younger people. • Use membership database to track changes in the composition of Trust's membership within these age groups	• Use membership database to track changes in the composition of the Trust's membership within these age groups
	Promote membership opportunities to younger people in our communities	• Pilot engagement opportunities in schools and colleges •		
	Refresh the membership pages on the Trust's website	• Refresh membership pages on the Trust's website to make them more accessible and informative.	• Keep membership pages up to date with new content • Make improvements based on feedback from membership survey.	• As year 2
	Articulate clearly the benefits of	• Define clear articulation of the benefits of being a	• Publish annual membership	• Publish second annual membership

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	membership	member of the Trust and ensure Governors are supported to articulate these benefits to potential members at events to meet 'your Governor'.	report which showcases work how the Trust has responded to issues raised by members	report which showcases work how the Trust has responded to issues raised by members
	Refresh our membership recruitment material	• Undertake review of existing membership recruitment and engagement material • Develop new material (e.g. posters, flyers) using the Trust's forthcoming new branding	• Review impact of the new materials through feedback from members via the membership survey and engagement events and refresh this where appropriate	• As year 2
	Work more innovatively with our partners to promote membership	• Identify a range of key partners to work with and explore opportunities for joint work to help recruit new members.	• Begin joint campaign with partner groups selected on recruiting new members, including members from under represented or hard to reach groups.	• Evaluate joint working with partner groups and identify further opportunities for engagement and recruitment of members.
Objective 2: To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged.	Promote the work of the Trust's governor, as representatives of our members	• Introduce a new contact email address for members to submit questions or raise issues with Governors, and publicise this on the membership pages on the Trust website. • Develop a model for Governor communication with Members tailored to local level. • Include a regular section focusing on the work of Governors in new electronic membership newsletter. • Develop promotional material and aids to promote the role and work of Governors, using the opportunity of the Governor elections in Winter 2020 to do this.	• Publish first annual membership report which showcases the work of Governors • Use second survey of membership to record member awareness of Governors • Develop video content for the Trust's website, where Governors talk about their work and their reasons for becoming Governors.	• Publish second annual membership report which showcases the work of Governors • Use third survey of membership to record member awareness of Governors

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
		• Governors to introduce member health talks • Governor participation in new constituency level events		
	Develop new opportunities for members to express their views	• Membership Engagement Committee to receive reports at each meeting on issues raised by members and actions being taken in response, and committee to report on these to the Council of Governors.	• Publish first annual report which showcases work on how the Trust has responded to issues raised by members	• Publish second annual report which showcases work on how the Trust has responded to issues raised by members
	Introduce new types of membership so members can choose how involved they want to be	• Confirm the definitions of the three levels of membership, ensuring these are sufficiently flexible to allow members to engage more or less depending on their areas of interest. • Introduce these categories on all new membership application forms • Contact existing members to confirm preferences on level of engagement and involvement	• Seek feedback from members through the membership survey to establish the degree to which the introduction of the new levels of membership has helped members have the opportunity to engage on the issues they care about • Use new levels of membership to target members for participation in surveys, workshops and focus groups • Monitor changes in number of members in each category as a proxy for measuring levels of active engagement	• Use levels of membership to target members for participation in surveys and workshops • Monitor changes in number of members in each category as a proxy for measuring levels of active engagement
	Refresh our existing ways of communicating with members and our approach to membership communication	• Launch new electronic membership newsletter which is visually more appealing and engaging and more informative about key developments in and affecting the Trust	• Undertake analysis of which issues and stories have been read most in the most in the membership newsletter.	• Launch third membership survey and reflect learning from this in activities to be delivered in the final year of the Strategy and in the planning of the new Membership Strategy from 2023.

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	and engagement	• Refresh membership pages on the Trust's website to make them more accessible and informative • Develop plans for an annual survey of members, refining key questions and issues where members feedback is needed	• Develop options for introducing a quarterly hard copy newsletter for staff, patients and the public. • Launch second membership survey and update Membership Strategy Actions Plan to reflect feedback from the survey.	
	Improve our programme of engagement events	• Develop plans for and launch pilot of constituency events in (TBC) constituency/s, introduced by Governor from that area. Assess impact and practicality of Member face to face meetings locally. • Develop a programme of member health talks for the full year ahead and seek views on topics for inclusion in future talks. Governor to be selected to introduce each speaker. • Seek to increase member turnout at Annual Members meeting by 20% (with a target of 100 attendees)	• Subject to feedback from constituency event pilots, roll out an annual programme of constituency engagement events (TBC) Constituencies. • Introduce updated member health talks with broader range of topics • Seek to increase member turnout at the Annual Members meeting by a further 20% (with a target of attracting over 120 attendees)	• Seek to increase member turnout at the Annual Members meeting by 25% (with a target of attracting over 150 members)
Objective 3: To ensure our staff members have opportunities to become more actively engaged as members	Increase support to staff governors	• Develop a suite of tools and resources specifically for staff governors • Develop a range of activities for staff governors to raise their profile and to engage with staff members, e.g. department walkabouts, drop-in sessions, sessions to build connections	• Review tools and resources for staff governors	•
	Develop a plan to increase awareness of	• Promote staff governors in a range of staff publications, hard copy ,	• Increase staff governor visibility in key areas of	• Seek to increase the number of staff members voting at

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	staff governors through staff induction and other training events	email and IT e.g. newsletters • Staff governor attendance at staff meetings and huddles by way of introduction • Introduce a generic email address for staff governors • Introduce staff governors at the staff induction day	the Trust • Survey of staff membership to record member awareness of Staff Governors	governor elections • Seek to increase the number of staff members interested in becoming a staff governor