Ref: MA/TH
Date: 23 September 2020

To the Members of the Board of Directors of Dorset County Hospital NHS Foundation Trust

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **30 September 2020 at 08.30am to 11.05am** in the CEO's Office and via Lifesize. This meeting will be recorded and made available to the public via the Trust website.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Nicky Lucey	Note	8.30-8.50
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	8.50-8.55
	a) Apologies for Absence: Mark Warner (Emma Hallett attending)	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 26 August 2020	Enclosure	Mark Addison	Approval	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approval	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	8.55-9.05
4.	**COVID-19 Update**	Verbal	Inese Robotham	Note	9.05-9.15
5.	**EPRR Assurance Process**	Enclosure	Inese Robotham	Note	9.15-9.20
6.	**ICS Update and DCH Priorities**	Enclosure	Nick Johnson	Note	9.20-9.40
7.	**Winter Plan**	Enclosure	Inese Robotham	Note	9.40-10.00
8.	**Health Inequalities**	Enclosure	Nick Johnson	Note	10.00-10.10
	Break 10.10 – 10.20				

9.	**Performance Scorecard and Board Sub-Committee Escalations**	Enclosure	Committee Chairs and Executive Leads	Note	10.20-10.40
10.	**Charity Annual Report and Accounts**	Enclosure	Paul Goddard/ James Claypole / Dave Underwood	Approve as Corporate Trustee	10.40-10.50
11.	**Decision Making Outside the Board**	Enclosure	Mark Addison / Trevor Hughes	Approve	10.50-10.55
12.	**Staff Survey Update**	Enclosure	Emma Hallett	Approve	10.55-11.05
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
13.	**Guardian of Safe Working Report**	Enclosure	Alastair Hutchison	Approve	
14.	**Any Other Business**				
	Nil notified				
15.	**Date and Time of Next Meeting**				
	The next Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on the **28 October 2020** via Lifesize.				

Minutes of a Meeting of the Board of Directors of Dorset County NHS Foundation Trust Held at 0900am on 26th August 2020 at the Board Room, Dorset County Hospital and via Lifesize.

Present:		
Mark Addison	MA	Trust Chair *(Chair)*
Sue Atkinson	SA	Non-Executive Director
Paul Goddard	PG	Director of Finance and Resources
Judy Gillow	JG	Non-Executive Director
Victoria Hodges	VH	Non-Executive Director
Nick Johnson	NJ	Director of Strategy, Transformation and Partnerships
Nicky Lucey	NL	Director of Nursing and Quality
Patricia Miller	PM	Chief Executive
Inese Robotham	IR	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Emma Hallet	EH	Deputy Director of Workforce
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
James Metcalfe	JM	Divisional Director, Urgent and Integrated Care
Kelly Upton	KU	HR Manager *(Item BoD20/116)*
Catherine Youers	CY	Deputy Director of Workforce *(Item BoD20/116)*

BoD20/116	**STAFF STORY**	
	KU and CY were welcomed to the meeting. KU discussed her experiences of suddenly needing to work from home during the COVID-19 pandemic as her child had a long term condition and was required to shield. Little information about COVID-19 or the impact this might have on her child's care and treatment was known at the time and KU had recently taken on additional responsibilities at work. Whilst KU had felt a great sense of team working and collegial support, she felt somewhat isolated and guilty that she was not 'pulling her weight'. KU compensated by over working. Her husband was also working from home. IT support and video conferencing provided opportunities to maintain liaison with colleagues, although KU reported that she had 'felt like the new girl' when she returned to work post shielding. VH thanked KU for her story and acknowledged the impact of changing working practices and environment on staff; particularly those experiencing difficult personal circumstances. VH noted the feelings of insecurity and need for empathy and to maintain connections with work and relationships with colleagues. SA commented on the feelings of guilt felt by those working from home and noted the practical difficulties associated with this working arrangement. SA stressed the need to provide appropriate support and the need for the difficult change to be acknowledged.	

	PM thanked KU for her observations and reflections and commented that many public sector workers were experiencing feelings of guilt. She added that the organisational culture should be such that staff felt trusted rather than monitored when working at home and that this would be an important consideration in the development of the People Plan. NL enquired how KU's experience would be used to support people working from home. KU highlighted the need to maintain regular personal interaction with collleagues, the need for staff to consider working arrangements from their colleagues' perspective and for staff to be able to confidently share their feelings and seek support given the significance of the change in working practices and environment. She added the need to ensure, and be supported, in maintaining an appropriate balance between managing home and work life commitments. MA thanked KU for her input and summarised the sense of guilt experienced by those working from home, the need for greater empathy for those working in significantly changed circumstances and noted the need for the establishment of a new 'contract' with staff based on trust. KU and CY left the meeting.	
BoD20/117	**FORMALITIES**	**Action**
	The Chair declared the meeting open and quorate. Apologies for absence were received from Mark Warner, Alastair Hutchison, Ian Metcalfe and Stephen Slough. MA welcomed EH to the meeting.	
BoD20/118	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the Agenda.	
BoD20/119	**Minutes of the Meeting held on the 29th July 2020**	
	There were no questions or points of accuracy raised in respect to the Minutes of the meeting held on 29th July 2020.	
	Resolved: that the Minutes of the meeting held on the 29th July 2020 be approved as an accurate record.	
BoD20/120	**Matters Arising: Action Log**	
	No matters arising were raised in connection with the Action Log and the Board agreed to close items completed. MA noted that committee Work Plans were not yet aligned to the model provided by the Quality Committee. He asked that this be progressed longside planned review of the strategy. ST noted the	**TH**

	Committee Chair's meeting planned in January 2021 to progress this work. SA requested an update on the Staff Survey action plan and it was agreed that this would be circulated to members and added to the Agenda in September.	**EH / TH**
	Resolved: that the Action Log be received and approval be given for the removal of completed actions.	
BoD02/121	**COVID-19 Update**	
	IR reported that prevalence remained low and that the DCH situation remained unchanged from that in June. She noted that a small number of patients requiring treatment for other conditions had tested positive and that one staff member and members of their family had also tested positive; contracting the infection whilst on leave in UK. IR reporterd that the infection had been detected on the staff member's return to work and robust track and trace measures were implemented with no wider consequences having been noted. IR advised that the Incident Management Team (IMT) remained operational whilst regional command and control arrangements also remained in place. Guidance on Infection Prevention and Control measures and clinical pathways continued to be received via the IMT and reporting requirements continued. MA enquired whether there had been any communication regarding a potential second wave. There had been no reliable modelling nationally and local system modelling, derived from local intelligence, had not indicated issues currently. NL confirmed that there had been no recent update derived from Public Health England modelling and noted that incident data was shared locally and nationally. There had been a slight increase in the number of cases nationally and JM advised that the potential impact of holidaying in the South West was being monitored closely.	
	Resolved: that the COVID-19 Update be received and noted.	
BoD20/122	**Gender Pay Gap**	
	EH advised that the detail of the paper had been fully considered by the Workforce Committee during the previous week. A detailed analysis and benchmarking with other trusts was to be undertaken in order to feed back to the Committee in February 2021 and to better understand the apparently widening gap, equal pay position and gender comparisons within medical and dental posts. Overall, men were paid 31% more than women within the trust and there were fewer men occupying posts in lower pay bands.	

	PM expressed disaapointment in the position given the national drive and data previously seen. She noted the need to embed actions to address the gap within the Equality Diversity and Inclusion (ED&I) work programme. MA noted concerns regarding the deterioration, the apparent pay banding disparity and need to include in prompt action within the wider ED&I agenda. He noted a recent publication via the NHS Health and Care Network which had highlighted a disproportionate COVID impact on women's longer term careers given their caring responsibilities.	
	Resolved: that the Gender Pay Gap be noted.	
BoD20/123	**Adult Inpatient Experience Survey Results**	
	It was noted that the report had been reviewed by the Quality Committee and that the Patient Experience Group would deliver the identified actions; providing assurance reports to the Quality Committee from September.	
	Resolved that: the Adult Inpatient Experience Survey Results be noted.	
BoD20/124	**Decision Making Outside the Board**	
	This item was deferred to the September meeting.	
	Resolved that: the process for Decision Making Outside the Board be deferred until September.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD20/125	**Integrated Performance Report**	
	Resolved that: The Integrated Perfformance Report be noted.	
BoD20/126	**Any Other Business**	
	No items of other business were raised or notified.	
BoD20/127	**Date and Time of Next Meeting**	
	The next meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust will be held on **30th September 2020** at **08.30am** via Lifesize.	

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Signed by Chair …….. Date ……..

Action Log – Board of Directors Part 1.

Presented on: 30th September 2020

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated:26th August 2020						
BoD20/120	**Matters Arising: Action Log**	Committee Work Plans to be aligned to the Quality Committee model following planned strategy discussions later in the year.	**TH**	**February 2021**	Not Due	No
		Staff Survey Action plan and report to be circulated and added to the Agendas for the September meeting	**EH / TH**	**September 2020**	Verbal update will be provided at the September meeting	Yes
Meeting Dated: 29th July 2020						
BoD20/104	**Integrated Performance Report**	Further discussion regarding performance of the Integrated Care System relative to South West partners to be had.	**PM / NJ**	**October 2020**	Report to resume in October	No
		Review current costs and run rate and produce an plan to reduce the current run rate	**PG**	**September 2020**	Item on part 2 Board Agenda	Yes
		COVID Risk assessments to be completed and recorded compliance levels reported	**MW**	**September 2020**	Assessments completed by 2.9.20: At risk staff 95% BAME staff 94% Overall staff 71%	Yes
BoD20/107	**Equality, Diversity and Inclusion Annual Report**	Assurance section to be included within the Action Plan.	**MW**	**September 2020**		
Part One Actions from Previous Meetings						

BoD20/006	**-**	Report front sheets to be updated to include risk appetite statement and social values.	**PM/TH**	**September 2020**	Revised format under consultation	Yes
BoD20/007	**-**	Dates of the series of events being planned to celebrate the contribution of EU staff to be circulated to the Board once finalised.	**PM/TH**	**When available**	Paused due to COVID-19	
BoD20/008	**-**	The Wessex Deanery had made it explicit that they wanted a change in the allocation of supervisory PAs in the Trust's consultant job plans. The Chief Executive to discuss this further with the Director of OD and Workforce.	**PM/MW**	**September 2020**	Verbal update to be provided at the September meeting by Emma Hallett on the latest position	Yes
BoD20/008	**-**	Integrated Performance Report amendments: • the 9 Must-Dos needed refreshing in line with the new guidance, • the Chief Executive to review the narrative and move away from performance reporting in siloes, • the pan-Dorset quality dashboard to feed into the Performance Report once received approved by the Quality Committee.	**PM**	**TBC**	This action has been superseded by the Phase 3 national letter directives	Yes
BoD20/009	**-**	The Director of OD and Workforce to review and score the issues relating to staff resilience, to see if this was an emerging risk which needed adding to the Corporate Risk Register.	**MW**	**March 2020**		
Actions from Committees…(Include Date)						

Board Strategic Work Programme Items Suspended due to COVID-19

Meeting	Items from Work Plan	Update
April 2020	• Equality and Diversity • Wellbeing • Sustainability	•
July	• Annual Complaints Report • Annual Clinical Audit Report	•
September	• Annual EPRR Statement • Annual GMC Statement • Review of Whistleblowing arrangements • Risk Appetite Statement Annual Review	•

Title of Meeting	**Board of Directors**
Date of Meeting	**30 September 2020**
Report Title	**Chief Executive's Report**
Author	**Natalie Violet, Corporate Business Manager to the CEO**
Responsible Executive	**Chief Executive**

Purpose of Report (e.g. for decision, information)
For information.

Summary

This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also included reflections on how the Trust is performing and the key areas of focus.

The key developments nationally are as follows:

Financial Allocations

Financial allocations have been issued to systems for the remainder of 2020/21. This is the first time total funding envelopes have been set at a system level and tied to system performance. An area of concern is that systems currently are not statutory bodies and as such do not hold any direct accountability. This remains with providers.

Health Inequalities and Oversight Group

The Health Inequalities Task and Finish Group concluded its initial work. Its recommendations were included in the phase three response from NHSE/I. The Health Inequalities Oversight Group has been created to provide oversight, scrutiny and advice on the delivery and further development of NHS actions to address health inequalities. It meets for the first time this month.

Equality, Diversity and Inclusion

A new series has been launched by NHS Providers which will focus on why inclusive leadership is more important than ever in the NHS. This will be a key focus of the forthcoming conference.

ED Capital

The Government announced on 17 September 2020 that 25 hospitals will receive a share of an additional £150 million of funding to upgrade. This is in addition to the £300 million announced recently for 117 Trusts to upgrade their facilities. Our organisation was included in this announcement and will receive £2 million for triage, minor injuries and a Priority Assessment Unit. A further £13m is expected next year with the aim of completion of these works by December 2021.

COVID-19 Vaccine Hubs

The UK Government has set up a national Vaccines Task Force to deliver COVID-19 vaccine trials across 18 UK regions, of which our area of Wessex is one. COVID-19 vaccine trials are already being delivered in Wessex, with more studies planned for the autumn and winter. These trials will last for the next 12-18 months. The Trust will store the vaccine for Dorset as we hold a wholesale

dealers licence.	
Paper Previously Reviewed By Chief Executive	
Strategic Impact In order for the Board to operate successfully, it has to understand the wider strategic and political context.	
Risk Evaluation Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation. The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.	
Impact on Care Quality Commission Registration and/or Clinical Quality An understanding of the strategic context is a key feature in strategy development and the Well Led domain. Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.	
Governance Implications (legal, clinical, equality and diversity or other): Failure to address significant strategic and operational risks could lead to regulatory action and significant deterioration in the Trust's performance against the 'Well Led' domain.	
Financial Implications Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

Chief Executives Report

Strategic Update

National Perspective

Local Relevance

Financial Allocations

Financial allocations have been issued to systems for the remainder of 2020/21. This is the first time total funding envelopes have been set at a system level and tied to system performance. In governance terms this is slightly concerning. Currently systems are not statutory bodies and as such are not directly accountable. Whilst this moves the NHS closer to 'system by default' it is important that this is supported by an appropriate governance framework.

It is expected that all system costs must be met from the envelope. This is based on the assumption that organisations will be able to recover their non-NHS income at speed. This may be a significant issue for the majority of Trusts as non NHS income is usually dependent on public footfall which is significantly reduced due to guidelines for managing COVID.

Allocations for COVID-19 have been calculated by rolling over costs during the first quarter of 2020/21, and stripping out one-off cost items for which there is national funding. COVID-19 may hit differentially in a possible second wave or as a result of widespread or recurrent local outbreaks. If there are significantly higher costs than expected, there is currently a lack of clarity on how they will be covered. The guidance states that, "in exceptional circumstances, the principles outlined in relation to funding for COVID-19 may need to be overruled". Details on how this will work are yet to be received.

Under the elective incentive scheme, money will be clawed back from ICS/STPs if ambitious recovery targets are not met. How this will work in practice remains unclear, the degree of flexibility if these targets are not met for good reason is currently unknown. Separate guidance will be provided by NHSE/I.

New Emergency Department Targets

Ministers have given NHSE/I approval to consult on the new metrics to replace the four-hour Accident and Emergency target before the end of the calendar year. The proposals for the consultation are yet to be finalised. It is likely the metrics will include:

- Time to initial clinical assessment in A&E
- Time to emergency treatment for critically ill
- Mean waiting time
- A change to the 12-hour metric; the clock will start from arrival in the department rather than the time a decision to admit is made

Public Health England

The Government confirmed it has replaced Public Health England (PHE) with a new organisation with the primary focus of public health protection and infection disease capacity. The new organisation has been named the National Institute for Health Protection (NIHP). Work will start immediately and will be formalised and operating from spring 2021.

Junior Doctor Training

The NHS has agreed a deal with private providers which will enable junior doctors to train in independent hospitals. The principles and guidance relates to organisations undertaking procedures in independent sector hospitals under the COVID-19 national contract. Historically it has not been routine for training to take place in the private sector. This is aimed to protect medical training, especially in elective specialty services, following the impact of COVID-19.

Health Inequalities and Oversight Group

The Health Inequalities Task and Finish Group concluded and the urgent actions to address inequalities in NHS provision and outcomes have been published. The eight urgent actions are included in the implementing phase 3 of the NHS response to the COVID-19 pandemic guidance.

The first Health Inequalities Oversight Group is due to meet on 25 September 2020. The group will provide oversight, scrutiny and advice on the delivery and further development of NHS actions to address health inequalities during the next phase of COVID-19 recovery and the renewed implementation of the NHS Long Term Plan.

Equality, Diversity and Inclusion

A new series has been launched by NHS Providers which will focus on why inclusive leadership is more important than ever in the NHS.

The series of online publications on racism and race inequality in the NHS will share a range of perspectives on how healthcare leaders can help to address structural inequalities, particularly for black, Asian and minority ethnic people working within the service. Over the next three months, it will highlight existing good practice in the NHS, alongside research, ideas and learnings from other sectors, and discuss what more is needed from the government as we seek to create a fair, just and healthy society for all.

The first blog in this series is from Patricia Miller and Raj Jain (Chief Executive at Northern Care Alliance NHS Group) which calls for all providers to have an honest conversation about racism and for leaders of health services to lead from the top in order to spearhead major change to tackle these inequalities and prejudices.

Workforce Race Equality Standard (WRES)

A bespoke set of WRES indicators have been developed for the NHS medical workforce. There are eleven indicators for the medical workforce. Four indicators reflect variation in career progression and pay, six represent medical staff perceptions of how they are treated by colleagues, employing organisations and patients, and one highlights the diversity of the councils and boards of medical institutions. A full set of data against these indicators will be analysed and presented as part of the annual WRES data report for NHS Trust later this year.

ED Capital

The Government announced on 17 September 2020 that 25 hospitals will receive a share of an additional £150 million of funding to upgrade, reduced overcrowding and improve infection control ahead of winter. This is in addition to the £300 million announced recently for 117 Trusts to upgrade their facilities. Our organisation was included in this announcement and will receive £2 million for triage, minor injuries and a

Priority Assessment Unit. A further £13m is expected next year with the aim of completion of these works by December 2021.

COVID-19 Vaccine Hubs

The UK Government has set up a national Vaccines Task Force to deliver COVID-19 vaccine trials across 18 UK regions, of which our area of Wessex is one. COVID-19 vaccine trials are already being delivered in Wessex, with more studies planned for the autumn and winter. These trials will last for the next 12-18 months.

In Wessex, NHS organisations across primary and secondary care have established the Wessex COVID-19 Vaccine Hub to run the trials. University Hospital Southampton (UHS) will be contracted to support the delivery of these vaccine trials through two or three sites across Wessex. There will be one site in Dorset and one or two sites in Hampshire. The Dorset site is at the Royal Bournemouth Hospital.

UHS has experience in delivering the Oxford Vaccine Group and Imperial College London COVID-19 vaccine trials. To replicate this successful working model across Wessex, the hub is looking at the workforce required which will include a team of doctors, nurses, healthcare assistants, administrators, pharmacy and laboratory staff and a range of other supporting roles and is looking to recruit from Dorset NHS trusts.

DCH Performance

Capital Investments

Over the past few weeks we have received good news in relation to our capital funding. We have received significant funding to improve our estate, including expanding our Emergency Department, increasing our Critical Care beds by a further two in preparation for winter and undertaking much needed maintenance work across the hospital.

Performance

In terms of performance NHSE/I have provided clear expectations with regard to restoring elective activity using comparable activity targets to last year's performance. The targets are ambitious and do not reflect the potential impact of a second wave of COVID-19.

The Trust will be required to submit details in relation to the impact a second wave would have against the activity predictions submitted as part of the system's operational planning submission to the Region. NHSE/I are keen that Trusts are able to separate COVID and non-COVID streams during the winter to prevent a significant loss off elective activity should a second wave materialise. Each region will be undertaking scenario planning for a second wave and Trusts will be engaged in this exercise going forward.

Winter Planning 2020/21

The Trust's winter plan has been completed and is on today's agenda for discussion. My biggest concern will be our ability to staff this safely. COVID has resulted in a slowing down of our overseas recruitment campaign. In addition should a second wave hit us we will have to manage staff sickness as well as absences due to shielding.

Flu Campaign

The Trust's flu campaign will be launched at the end of the month. Our staff are being encouraged to get their annual flu jab as soon as possible. This year's campaign will be a little different to those of previous years. For the first time, staff who are aged 65 and over

will be able to receive the vaccine on site. Our allocation of vaccines will be received in four batches which means we will be offering the vaccine to certain staff groups using a phased approach with our team of Peer Vaccinators. It is anticipated we will offer the vaccine to all staff by mid-October.

Staff Wellbeing

The wellbeing of our workforce remains at the top of our agenda. With the possibility of facing a second wave of COVID we are continuing to support our staff through a range of wellbeing services.

Other News

Within in the organisation 1800 staff have received an individual COVID risk assessment, as at the beginning of September 95% of 'at risk' staff have been assessed. Within this 94% of black, Asian and minority ethnic staff have been assessed. Our teams are continuing to focus on achieving 100% and to ensure assessment reviews are undertaken to ensure any changes to an individual's health condition are captured and the position reassessed.

We received some very positive news; on 15 September 2020 Dorset Council's Planning Committee unanimously approved our planning application for the multi-story care park. This is an important first step towards our Estates Masterplan to improve our clinical facilities and environment for both our patients and staff.

Patricia Miller, Chief Executive
30th September 2020

Title of Meeting	**Board of Directors**
Date of Meeting	**30 September 2020**
Report Title	**Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21**
Author	Tony James, Head of Emergency Planning & Resilience
Responsible Executive	Inese Robotham, Chief Operating Officer, Accountable Emergency Officer (AEO)

Purpose of Report (e.g. for decision, information
To advise the Board of the NHS&I Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21

Summary
The paper sets out the amended process for 2020/21 which will focus on three areas:

A. progress made by organisations that were reported as partially or non-compliant in the 2019/20 process
B. the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic
C. inclusion of progress and learning in winter planning preparations.

Paper Previously Reviewed By:

- Accountable Emergency Officer (COO)
- Emergency Planning & Resilience Group

Strategic Impact
Robust systems for EPRR ensure that the Trust complies with relevant provisions of the Civil Contingencies Act (2004) and the Health and Social Care Act (2012).

Risk Evaluation
An update on the 2019/20 partially compliant domains and the identification and embedding of learning through an appropriate process.

Impact on Care Quality Commission Registration and/or Clinical Quality
CQC Regulations 12: Safe care and treatment. 'To make sure that people who use services are safe and any risks to their care and treatment are minimised, providers must be able to respond to and manage major incidents and emergency situations'.

Governance Implications (legal, clinical, equality and diversity or other):
The Trust needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006 (as amended).

Financial Implications
None

Freedom of Information Implications – can the report be published?	No
Recommendations	The Trust Board is asked to note the Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21.

Title of Meeting	**Board of Directors**
Date of Meeting	**30 September 2020**
Report Title	**Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21**
Author	**Tony James, Head of Emergency Planning & Resilience**

1. Introduction

1.1 The events of 2020 have tested all NHS organisation plans to a degree above and beyond that routinely achievable through exercises or assurance processes. However, our statutory requirement to formally assure ourselves of EPRR readiness in our own organisation remains.

1.2 It has been recognise by NHS England and NHS Improvement that the detailed and granular process of previous years would be excessive while we prepare for a potential further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services.

1.3 This year amended assurance process for 2020/21 focuses on three areas:

A. progress made by organisations that were reported as partially or non-compliant in the 2019/20 process

B. the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic

C. inclusion of progress and learning in winter planning preparations.

2. Progress of partially or non-compliant organisations

2.1 The Trust was rated partially compliant in the 2019/20 process and has worked to address gaps. Much of this was carried out ahead of the COVID-19 pandemic.

2.2 Four domains remain at partially compliant**:**

- Mass counter-measures
- Mass Casualty - patient identification
- Mutual aid arrangements
- Data Protection and Security Toolkit

2.3. Our EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.

3. The identification and application of learning from the first wave of the COVID-19 pandemic

3.1 The comprehensive and extensive response to the first wave of the COVID-19 pandemic has provided all health organisations with a unique opportunity to identify and embed lessons into EPRR practice. The 2020/21 process seeks to ensure that all NHS organisations have begun the process to systematically and comprehensively identify, learn and embed lessons to improve EPRR practice.

4. Incorporating progress and learning into winter planning arrangements

4.1 As in previous years there is also a wider programme of winter planning and assurance. This work will draw on existing processes, including this one, to supplement assurance conversations. The 2020/21 process seeks to ensure this learning is embedded in winter preparedness.

5. Action to take / next steps

5.1 To assist the CCG in preparing the final assurance statement the Trust is required to provide the following:

- Ensure representation by a lead CoVID-19 responder at the Dorset CoVID-19 Health & Care Silver - Mid Incident Structured Debrief Session on 7 October
- Submit previous CoVID-19 learning and debriefing documents by 30 September
- A Trust level statement confirming our progress against points A, B and C (see section 1.3) above. By 16 October.
- A clear statement in a letter to the CCG detailing learning identified from the first phase of COVID-19. By 16 October.
- Submission of the post incident recommendation tracking document detailing how identified learning is actively informing plans for this winter. By 16 October.
- Accountable Emergency Officer (AEO) and EPRR lead to attend an assurance confirm and challenge meeting with the CCG AEO supported by NHSE&I South West on 26 October.

5.2 CCG/ICS statements of assurance will subsequently be presented to the Local Health Resilience Partnership (LHRP) Executives for information and discussion during quarter four meetings.

6. Recommendations

6.1 The Trust Board is asked to note the Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21.

Title of Meeting	**Trust Board**
Date of Meeting	**30th September 2020**
Report Title	**ICS Developments and DCH Priorities for 2020/21**
Author	Nick Johnson, Director of Strategy, Transformation and Partnerships
Responsible Executive	Nick Johnson, Director of Strategy, Transformation and Partnerships

Purpose of Report (e.g. for decision, information) For information

Summary. This report summarises the latest positon with regard to the proposed Dorset Integrated Care System priorities and governance approach and confirms the agreed DCH Priorities for 2020/21.

Paper Previously Reviewed By
Execs

Strategic Impact
DCH is committed to the Dorset Integrated Care system. Integration of services is core to the DCH Strategy.

Risk Evaluation
Failure of the Dorset ICS will mean significant lost benefits for DCH. Lack of engagement by DCH in the ICS will potentially lead to unpalatable system decisions or future directions for DCH.

Impact on Care Quality Commission Registration and/or Clinical Quality
None arising from the report. It is noted that the ICS has no statutory effect.

Governance Implications (legal, clinical, equality and diversity or other):
None arising from the report. It is noted that the ICS has no statutory effect and decisions remain with the Trust.

Financial Implications.
None arising from the report.

Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board • Notes the ICS priorities and updates • Notes the agreed DCH Priorities for 2020/21

1. Introduction

1.1 This report summarises the latest positon with regard to the proposed Dorset Integrated Care System priorities and governance approach and confirms the agreed DCH Priorities for 2020/21.

1.2 This report does not provide a summary of the ICS/DCH Operational Plan submission.

2. Background and Context

2.1 Dorset Integrated Care System (ICS) was formally established in 2018. An independent review of the ICS was undertaken in 2019 which outlined a number of areas of development themes including appointment of an Independent Chair, refresh of the vision, values and behaviours, governance and decision making and clear priorities.

2.2 In February 2020, the Dorset System Partnership Board (SPB) came together to take forward the recommendations in the review, understand where we are performing against the national ICS Maturity Matrix and the actions required toenable us to be a thriving ICS.

2.3 Two of the key actions required by the SPB were to:

- develop clear priorities for the system;
- review and develop clear governance arranged for the ICS

2.4 In March 2020 the NHS mobilised to deal with the Coronavirus pandemic. Following the first two phases of the response, NHSEI issued a 'Phase 3' Letter on July 31st setting out the requirements for the NHS until the end of the 2020/21 period. The Dorset ICS is required to submit a joint operational plan to cover this period.

2.5 Separately DCH has developed a set of priorities for internal use and guidance. These are closely aligned with the ICS Priorities and also the Phase 3 Operational Plan, although they are tailored to meet DCH requirements.

3. Key Points

3.1 ICS Priorities

3.1.1 **At the SPB on the 18 June 2020 partners set out a proposed vision and purpose for Dorset ICS, which brings together all system partners as follows:**

• Our Vision is: *working together to deliver the best possible improvement in health and well being*
• Our Purpose is: *to transform the planning and delivery of local health and care services*

3.1.2 In the context of the revised vision and purpose it is proposed to recognise that three key dynamics need to be considered when developing the priorities for the ICS, which are as follows:

- Full partnership- these are priorities which all partners have a role in delivering, and we can get best outcomes by working together
- Health and Care- these are strategic priorities which would require health together with adult and children social care to work together
- NHS - these are predominantly NHS operational performance related priorities, but some do require social care in order to be delivered.

3.1.3 The proposed draft priorities within each tier can then be built up around the partners that are required to deliver them, as seen in the table below.

Tier 1- Health and Wellbeing	Tier 2- Health and Care Strategic	Tier 3- NHS and Social Care Operational

• Place- focussing on high service users
  • Boscombe and West Howe
  • Weymouth and Portland
• Health Inequalities
  • Minority communities
  • Children and young people
  • Mental health
  • Vulnerable groups
• Population health management
• Social value and the role of anchor organisations, active lifestyle
• Workforce- Dorset as a good place to work
	• Implement Clinical Services Review decision i.e.
	  • Royal Bournemouth Hospital and Poole merger
	  • Major planned/ major emergency sites
	  • Dorset County Hospital A&E and site reconfiguration
	  • Primary and Community Care Strategy- ICPCS, PCNs, hubs, integrated teams, Home First
	• Acute Mental Health Pathway
	• Dorset Care Record
	• Finance- sustainability
	• Quality- all provider CQC good or above
	• Workforce – sustainable workforce, reduce reliance on agency
		• Phase 3 Recovery
		• NHS 6 core targets
		  • 52 weeks
		  • 18wk RTT
		  • 62d cancer
		  • 4hr A&E wait
		  • 6wk diagnostic
		  • IAPT
		• PCNs development
		• Mental health
		• Urgent and Emergency Care
		• Workforce
		• Finance
		• Digital
		• Quality
		• National and local operational priorities

3.1.4 Further work is required to develop the Health and Wellbeing priorities in Tier 1. It is recognised that there is potential to have crossover/duplication of work and/or

reporting with that of the Health and Wellbeing Boards, therefore a working group has been established to further define these priorities.

3.2 ICS Governance

3.2.1 In developing the proposed draft governance arrangements several factors had to be considered, as follows:

• the ICS currently has no formal delegated decision-making authority- it is a collaboration of partners, therefore:

○ decisions can only be made where statutory organisations have developed certain powers to the officers attending or any decisions in line with existing decision the statutory organisation has already taken

○ SPB/SLT can agree the direction of travel and agree any decisions that need to go back to the statutory organisation for formal decision making

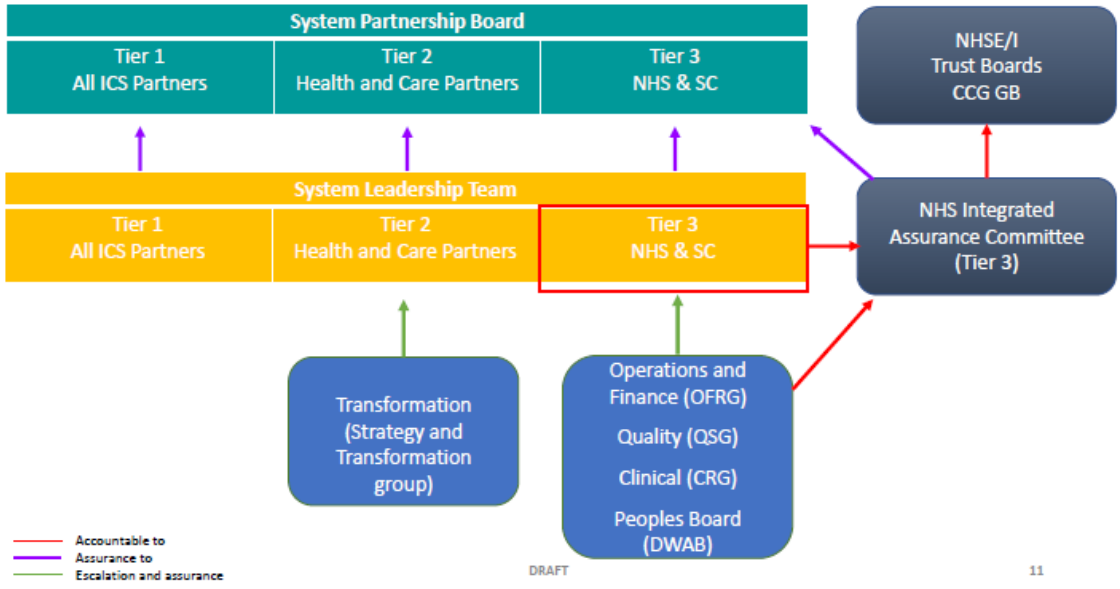
• formal oversight and assurance requirements set out by NHS England/ Improvement that relate to NHS partners only

• requirement to make best use of peoples and organisations time – right conversation at the right level

• provide programmes/groups with the authority to act rather than escalating issues up to SLT/SPB.

3.2.2 As illustrated below the proposed governance has been based around the three levels of priorities, with the introduction of a NHSE Integrated Assurance Committee.

3.2.3 Assurance will be provided up to SLT through the relevant sub-groups (Operations and Finance Reference Group (OFRG), Quality Surveillance Group (QSG), Clinical Reference Group (CRG), People's Board, Strategy and Transformation).



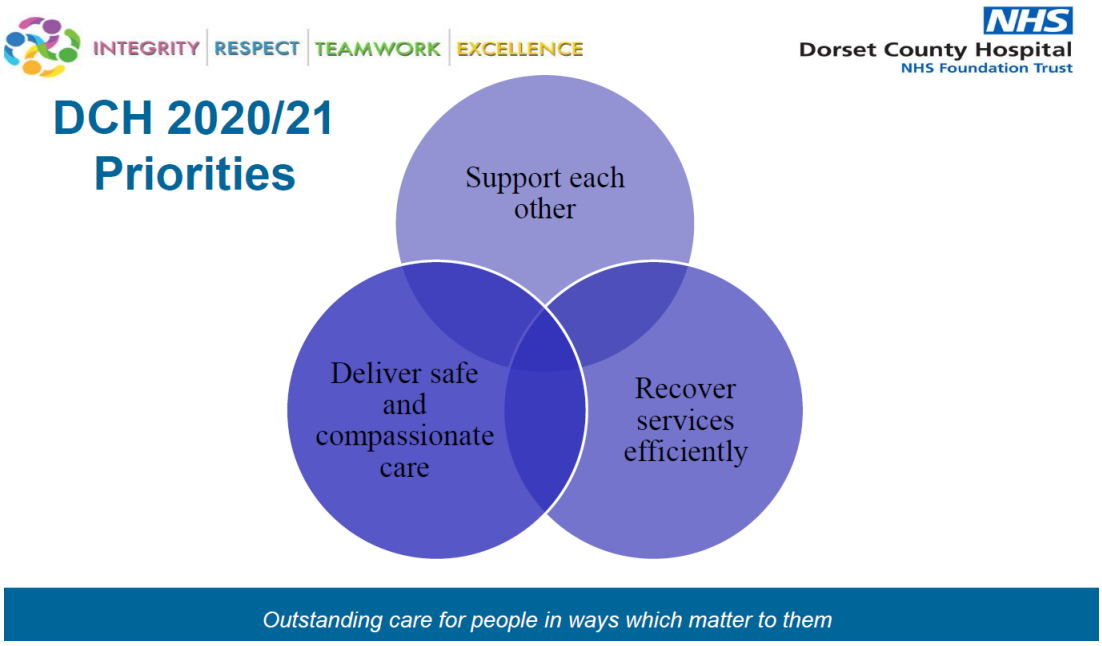
3.2.4 A summary of the role and membership of the SPB, SLT and NHSE Integrated Assurance Committee can be seen below (further details can be seen in Appendix 1)

3.2.5 Further work will be required on the role and membership of the sub-groups and programmes and this will be taken forward once the overarching governance has been agreed.

3.2.6 Following feedback the next steps will be to:
• update priorities and governance proposal in line with feedback
• seek approval from the SPB in October 2020.

3.3 DCH 2020/21 Priorities

3.3.1 The proposed DCH 2020/21 Priorities were set out in a report to the last Trust Board. Further to the report comments and feedback were requested from Trust Board virtually. The more detailed DCH 2020/21 Priority framework is set out in Appendix 2. In summary the priorities are:



4. Recommendations

The Board

- Notes and comments on the proposed ICS prioritisation and governance approach
- Notes the agreed DCH Priorities for 2020/21

ICS Priorities and ICS Governance

DRAFT for discussion

Dorset ICS Priority Framework

The proposed framework reflects the following aspects:

- 3 different dynamics at play in the ICS
    - Full partnership
    - Health and Care
    - NHS only
- Make best use of peoples time e.g. Full ICS where Police and Fire can also contribute, NHS only when its NHS performance issues (Tier 3)
- Governance reflective of 3 tier priorities
- Formal oversight and assurance required by NHS England and Improvement which only applies to NHS partners

Proposed vision and purpose

Our Vision is:

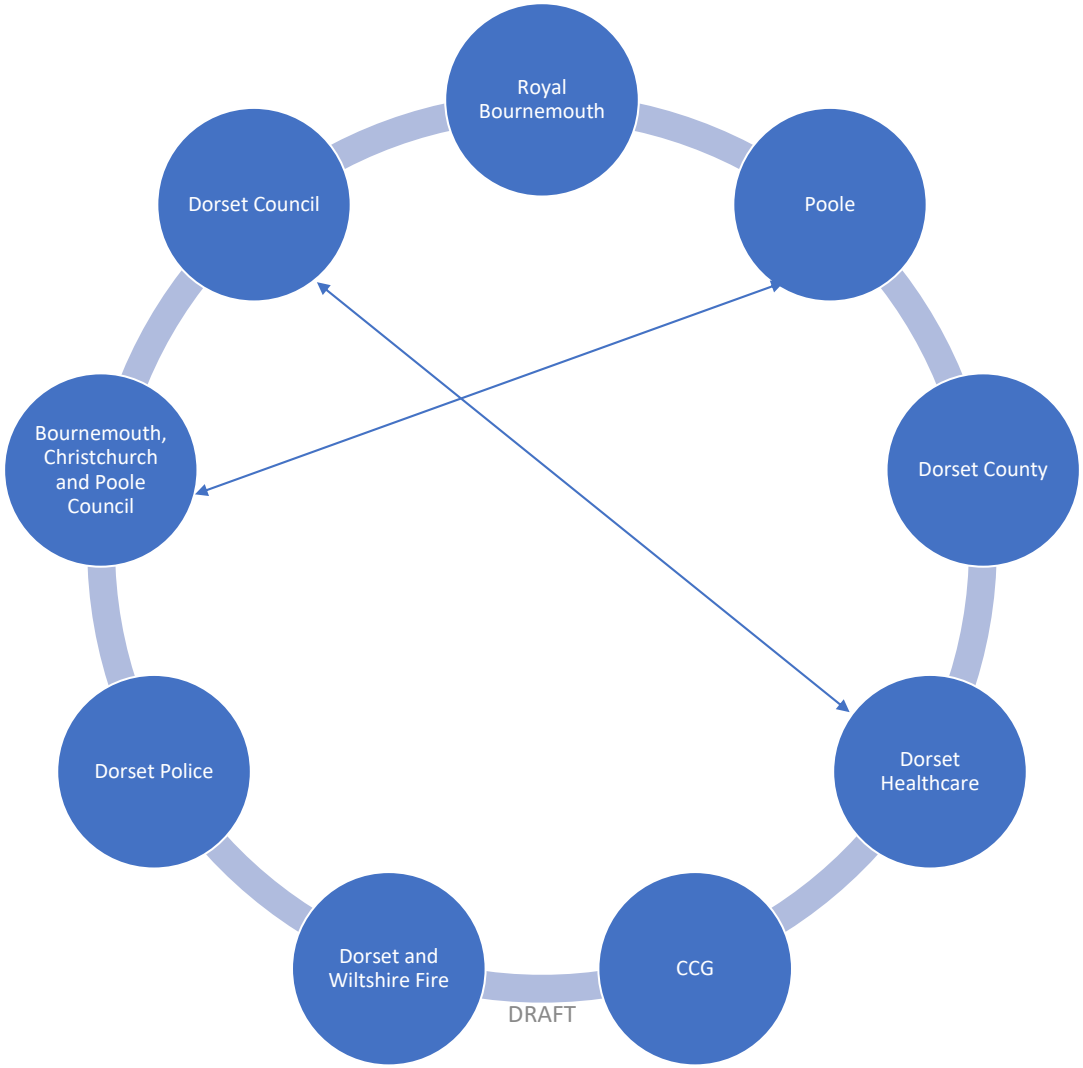
Working together to deliver the best possible improvements in health and well being

Our Purpose is:

To transform the planning and delivery of local health and care services

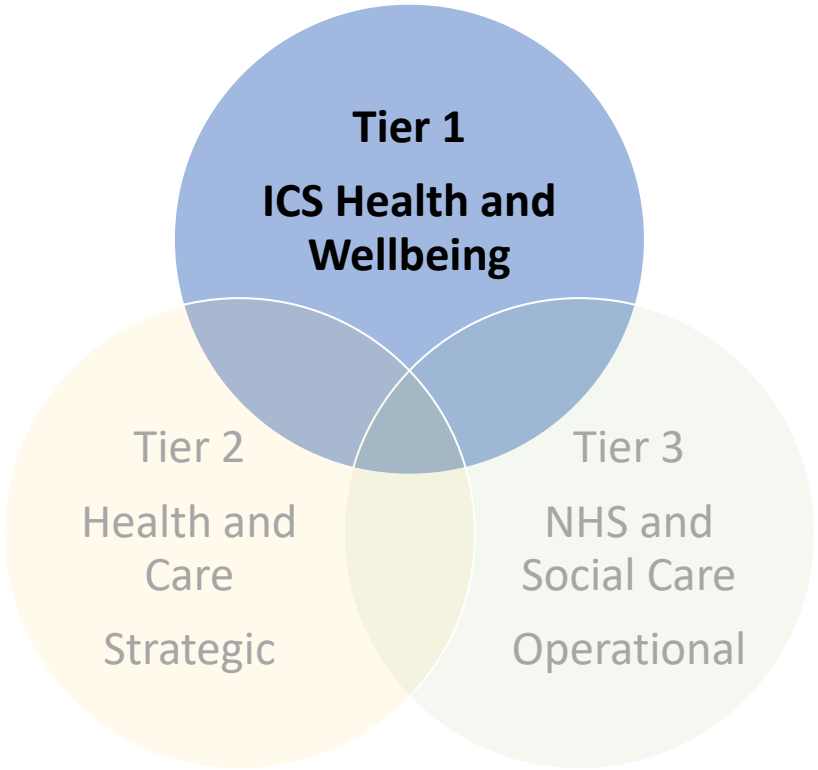
Partnership approach

Organisation to Organisation



Dorset ICS Priority Framework

Tier 1 ICS Health and Wellbeing- focus on health



Includes:

- All ICS partners

Priorities:

- Place- focussing on high service users
  - Boscombe and West Howe
  - Weymouth and Portland
- Health Inequalities
  - Minority communities
  - Children and young people- SEND/ Looked After Children/ Mental Health
  - Mental health
  - Vulnerable groups
  - Learning Disabilities
- Population health management
- Social value and the role of anchor organisations, active lifestyle
- Workforce- Dorset as a good place to work
- Priority issues e.g. pandemic, winter

Do we agree these are our ICS Health and Wellbeing priorities?
What is the relationship with the HWB Boards?

DRAFT

Tier 2 Health and Care Strategic

Includes:

- NHS partners
- Local authority – adults and children services

Priorities:

- Implement Clinical Services Review decision i.e.
  - Royal Bournemouth Hospital and Poole merger
  - Major planned/ major emergency sites
  - Dorset County Hospital A&E and site reconfiguration
  - Primary and Community Care Strategy- ICPCS, PCNs, hubs, integrated teams, Home First
  - Social care market
- Acute Mental Health Pathway
- Dorset Care Record
- Finance- sustainability
- Quality- all provider CQC good or above
- Workforce – sustainable workforce, reduce reliance on agency

Do we agree these are our Health and Care strategic priorities?
What are the Local authority priorities we need to include?

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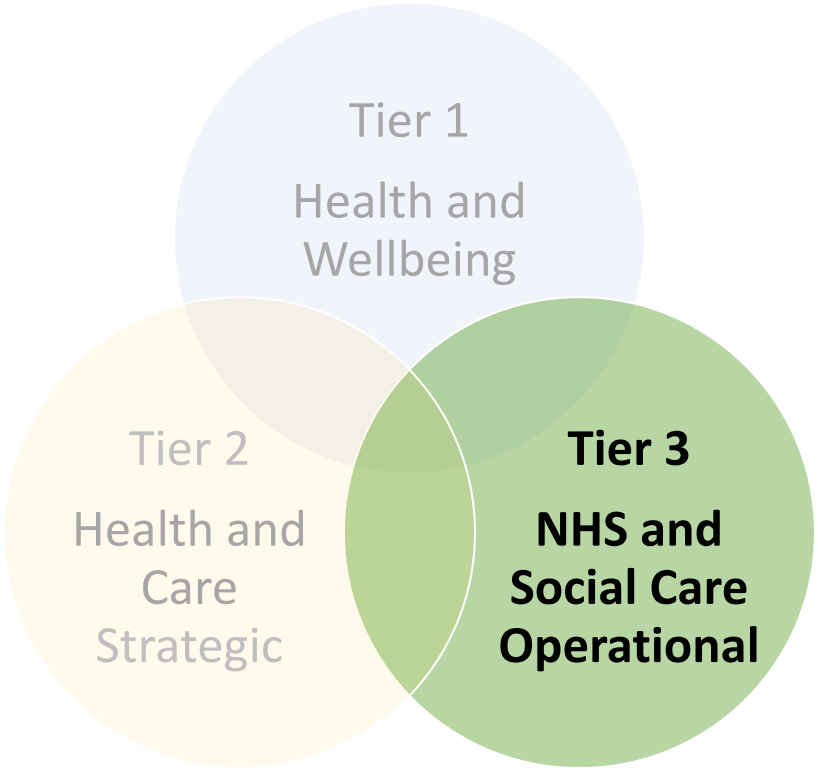
Tier 3 Health and Care Operational



Includes:

- NHS partners
- Local authority – children's and adults social care

Priorities:

- Recovery- see slide 9
  - RTT and Waiting list (52 weeks, 18wk RTT, 6wk diagnostic, 62d cancer, 4hr A&E wait, IAPT
- PCNs- ICPCS, PCNs, hubs, integrated teams, Home First
- Social care market
- Mental health
- Learning Disabilities and autism
- Children's Services
- Urgent and Emergency Care
- Workforce
- Finance
- Digital
- Quality

Are these our Health and Care operational priorities?
What are the Local authority priorities we need to include?

Tests	Do we understand need/demand (incl winter/second peak)?	Do we understand our capacity to deliver against the need?	Do we have plan to bridge the gap ?	Does our plan address inequalities that exist?	Have we identified risks and mitigating actions?	Have we identified comms and engagement requirements?	Do we have the right people involved ?

RECOVERY PRIORITIES

Sector/ Area	Priority 1- Critical	Priority 2- Urgent	Aim (links to NHSE/I 7 test)	Clinical Lead	Chief Exec and Management Lead (suggestions)
Social care	Home First programme	Social prescribing, self care/ reliance, care homes, Long Term Condition Management, shielding	To accelerate the model for more integrated primary, community and social care, including new home first pathways	PCN clinical directors	Eugine Yafele Jan Thurgood Vivian Broadhurst Kris Dominy Sally Sandcraft
Primary and Community Care		GP/PCNs 'Living with Covid & Business Continuity, Digital solutions		GP Clinical Leads	
Mental Health	IAPT, psychiatric liaison, bed capacity Children and Young People Mental Health	MH after (Covid) care, SMI health checks, homelessness, domestic violence, safeguarding, psychosis rise	To provide appropriate care for those who have not presented during Covid both current and emerging	TBC	Eugine Yafele/ Kris Dominy Sally Sandcraft
Urgent Care	Optimise ED capacity, efficiency and safety. MIU pathways Strengthen 111	Alternative pathways for ambulance Same day emergency care Non –cancer latent demand	Optimise urgent care capacity, minimising the risk to patients and staff whilst whilst living alongside Covid	TBC	Patricia Miller Sue Sutton
Cancer	Latent demand Endoscopy (incl screening)	Retaining use of ISPs being used at maximum capacity	Minimise/clear the elective backlog and create maximum capacity	TBC	Debbie Fleming Cindy Shaw Fletcher
Elective care & diagnostics	52 weeks, Endoscopy	Ophthalmology, Orthopaedics, ENT, Oral Surgery (NHSE comm), Audiology	Optimise capacity to minimise the elective backlog and manage future demand	TBC	Debbie Fleming Sally Banister
Covid treatment and critical care capacity	Critical care capacity- beds, rehab, transport	Primary care Covid treatment pilot	Establish sufficient and maintain critical care demand and service infrastructure to meet future Covid-19 and non Covid demand	TBC	Richard Renaut Sally Banister
Staff wellbeing and numbers	Workforce planning Equality and Diversity	Staff health and wellbeing support, mutual aid and flexible working.	Address staff wellbeing Better collective workforce planning	Dr Forbes Watson	Emma Shipton
Dorset reset	LTP #2 -ICS operating model including financial framework, governance and oversight and assurance frameworks. Develop the new landscape and role of the role of ICSs Delivery to date, future models of care, how we will work together and he supporting governance and oversight				Tim Goodson/ Phil Richardson/ Nikki Rowland

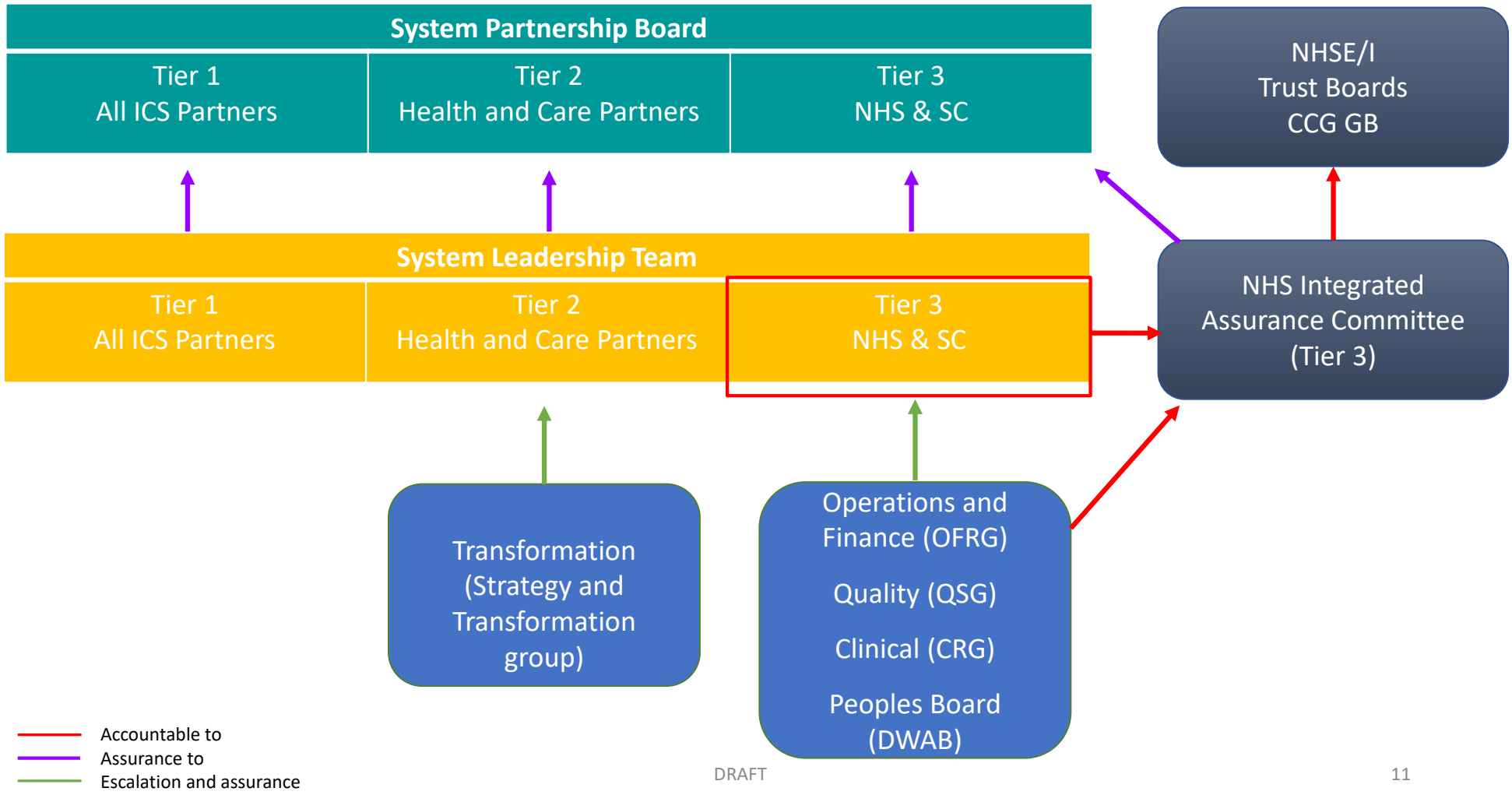
Principles	People First	Home and community focussed	Embed quality improvement gains	Innovation through digital first	Evidence based and needs led	Proactively supporting staff	Do it once, do it at pace, do it together	Safety first

Dorset ICS Governance Framework

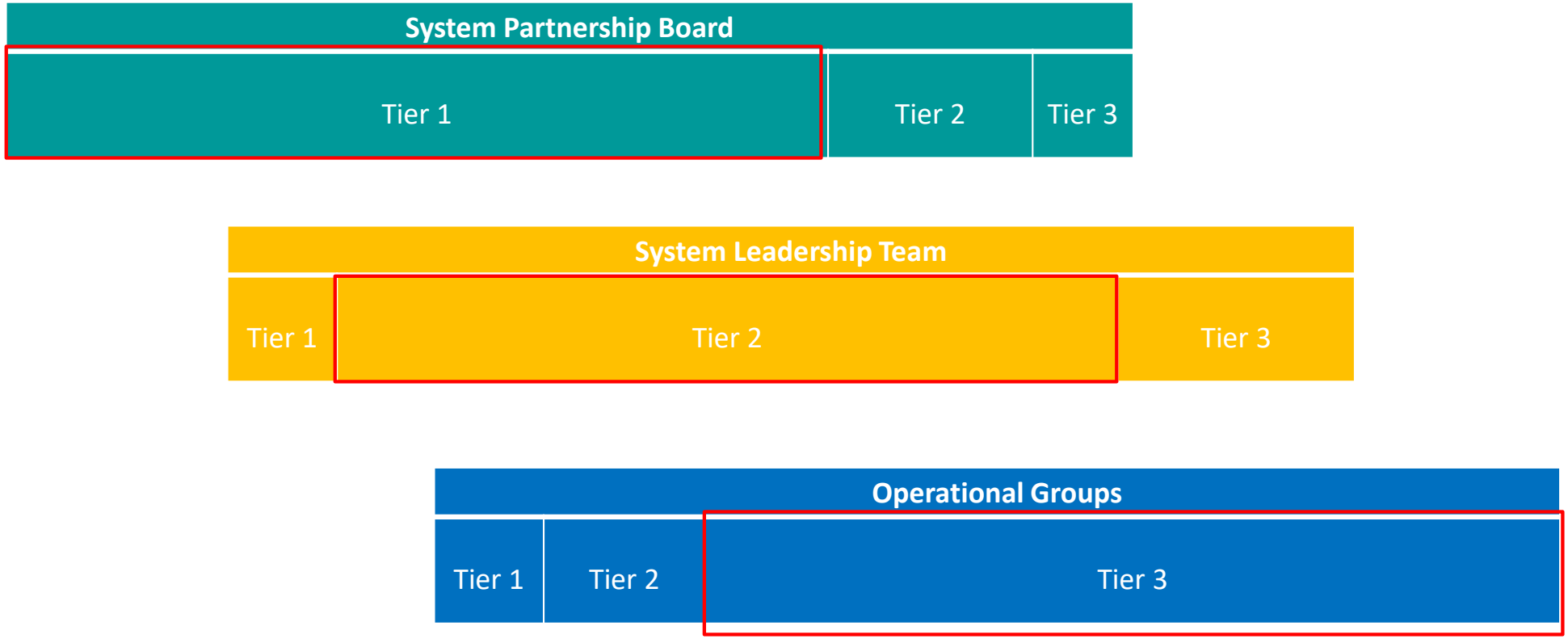
The proposed framework reflects the following aspects:

- No formal devolved delegation has happened by any organisation to the SPB or SLT
- The SPB and SLT agree direction of travel and agree any decisions that need to go back to statutory organisations for the statutory decision to be taken
- The only decisions that can be taken at SPB and SLT are those where statutory organisation have devolved certain powers to the officers at the meetings, or any decision are already in line with existing decisions that the statutory organisations have already taken.
- Decisions should be taken as close to the front line as possible rather than escalate everything up
- Each group to hold itself and partners to account for delivery
- The Governance and meetings should be structured to make the best use of different people and organisations time. This could be done by mirroring the priority tiers and splitting meetings into separate parts around the tiers
- Formal oversight and assurance required by NHS England and Improvement which only applies to NHS partners.

Dorset ICS - Governance for discussion



Dorset ICS – Where should attention be focused.



System Partnership Board

Purpose	Role
• Provides a joint forum between health providers and commissioners, local authority, police and fire partners across Dorset, to come together to set the strategic priorities which require closer working across all sectors. • Develop and foster close relationships and system working at place level across Dorset ICS. • Develop and deliver the system strategy and ensure delivery of Tier 1 priorities	• Working as a collaborative to provide the strategic direction for the system • Advise and steer the development of Dorset Long Term Plan #2 • Oversight and delivery of Tier 1 priorities and key strategic issues identified within Dorset *Reports received:* • Update report from SLT • Assurance report from the NHS Integrated Assurance Committee • Annual Operational Plan- approval through SLT • ICS Strategic Plan- for comments and approval • Annual Report – do we want to do an annual report for the ICS against outcomes
Membership	**Accountability**
Chair- Jenni Douglas-Todd (Independent Chair) **Non-executive** • NHS Chairs • LA Leaders • Police and Crime Commissioners • Chair Fire Service • Health and Wellbeing Board Chairs **Executive** • ICS Leader • NHS Chief Executives • LA Chief Executives • Chief Constable Police • Chief Fire Officer • Director of Public Health	• It will be responsible for the delivery of and oversee the achievement of Tier 1 • It will receive assurance from the Integrated Assurance Committee for Tier 2 & 3 priorities • It is not a decision making group – decisions continue to be made by the statutory organisations. Only decision it can make are those where the delegated authority rests with its individual members. • Meeting frequency: bi monthly

What should the links to the HWB be?

System Leadership Team

Purpose	Role
• Key executive group comprising of executive members from the Dorset Health and Care system to develop and deliver the system strategy and ensure delivery of Tier 2 and 3 priorities • Provides a collaborative forum to ensure alignment of priorities across the system where strategic and operational issues relating to health and care are discussed and driven forward • Escalation route for system issues where these are unable to be resolved in its relevant sub group or programmes	Executive responsibility for delivery of shared health and care priorities across including: • System strategy and planning for health and care services (Tier 2&3) • System delivery and performance for health and care services (Tier 2&3) • System transformation delivery of health and care services (Tier 2&3) *Reports received:* • Escalation and progress reports from subgroups OFRG, CRG and QSG,?DWAB • Deep Dives into areas of concern or new programmes • Annual Operational Plan- for comments and approval • ICS Strategic Plan- for comments and approval
Membership	**Accountability**
Chair: Tim Goodson (ICS Leader) **Executive** • NHS Chief Executives • LA Director of Adult Social Care • LA Director of Children Social Care • Director of Public Health • Primary Care – provider representation **Invited:** • Chair of OFRG • Chair of QSG • Chair of CRG • Chair of DWAB • Chair of Strategy and transformation (currently not in place) • Head of Planning and Assurance • Local Medical Committee	• It will oversee the achievement of Tier 2 and 3 priorities • Accountable to the Integrated Assurance Committee for Tier 2 & 3 priorities who provide assurance to SPB and NHSEI, Trust Boards and CCG Governing Body • It is not a decision making group – decisions continue to be made by the statutory organisations. Only decision it can make are those where the delegated authority rests with its individual members • Meeting frequency: monthly

NHS Integrated Assurance Committee

Purpose	Role

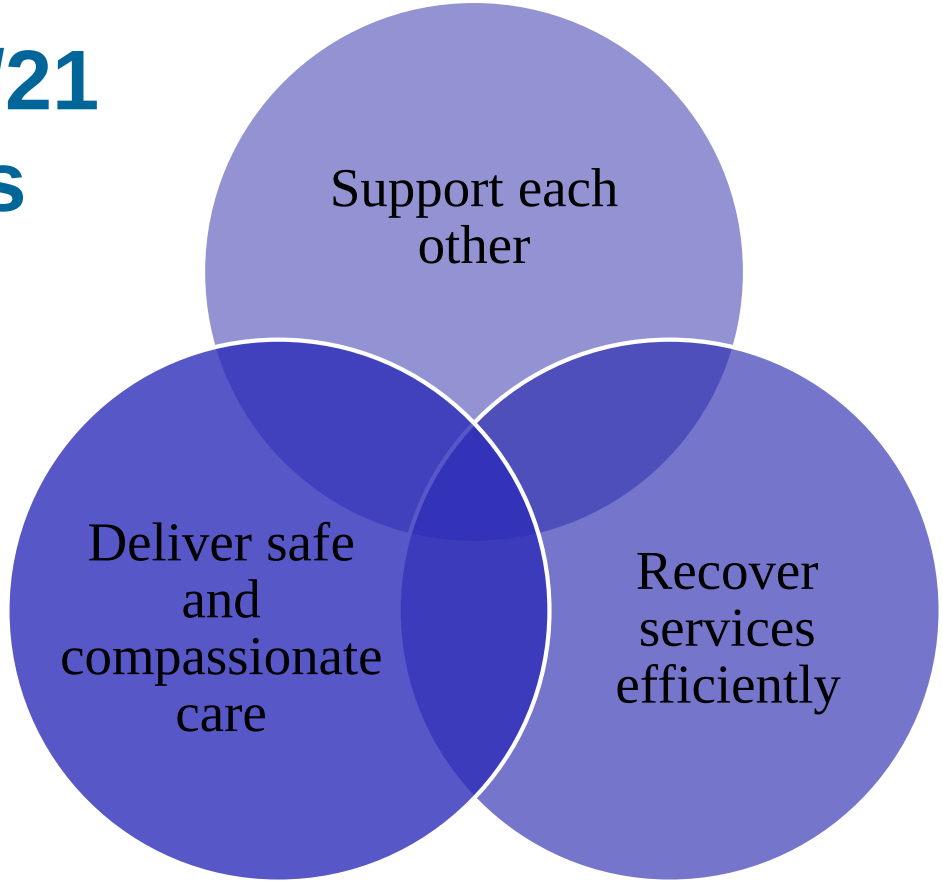
To provide assurance on the NHS/I performance metrics and operational standards
 	
Provide assurance to Trust Boards, CCG Governing Body and Regulators
	• Scrutinise system level delivery of priorities, identifying key risks and mitigating actions for:
	  • Finance
	  • Operational performance
	  • Quality and safety

Membership	**Accountability**
Chair: Non Exec/ Lay Member • Lay member/ non executive for health **Invited:** • Chair of OFRG • Chair of QSG • Chair of CRG • Chair DWAB • ICS Leader • NHS Provider Chief Executive Representative	• It will provide assurance of the achievement Tier 3 priorities to Trust Boards, CCG Governing Body and Regulators • Not a formal decision making group but will make recommendations on action required in relation to additional assurance required • Meeting frequency TBC

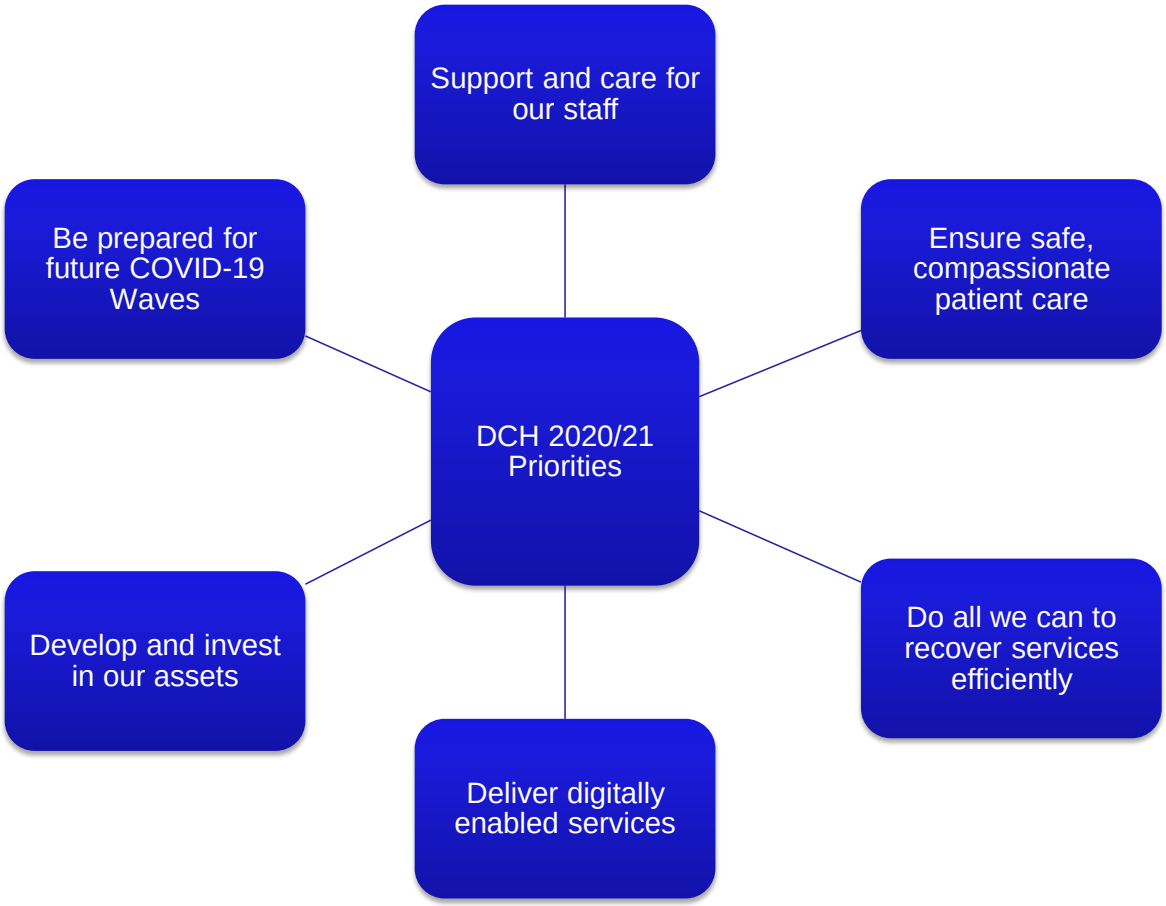
DCH 2020/21 Priorities

Outstanding care for people in ways which matter to them

DCH 2020/21 Priorities



Outstanding care for people in ways which matter to them



Outstanding care for people in ways which matter to them

- Keep staff safe, healthy and well, both physically and physiologically
- Promote equality and celebrating diversity
- Engage and support staff in shared learning and quality improvement
- Drive substantive recruitment and agency spend reduction

Support and care for our staff

- Adhere to national IPC guidance and minimise hospital cross infections
- Ensure patients are seen in clinical priority by the right person, in the right environment, with minimal visits to the hospital

Ensure safe, compassionate patient care

- Deliver efficiencies and reduce financial run rate
- Full operation of cancer services, restart of elective services and ensure sufficient diagnostic capacity
- Monitor performance of service use and outcomes among those from most deprived neighbourhoods and BAME communities

Do all we can to recover services efficiently

- Maximise on the digital tools adopted during COVID
- Maximise on the availability of digital platforms to deliver virtual outpatient consultations, where clinically appropriate
- Progress our Digital Strategy, learning from our COVID experiences

Deliver digitally enabled services

- Implement structural changes within the hospital as part of our COVID recovery
- Drive forward with our plans for the new ED, ICU and integrated services hub

Develop and invest in our assets

- Deliver seasonal flu vaccination and ensure access to Covid testing
- Have our Covid surge plans in place to implement and flex resources
- Develop a local Winter Plan, taking learning from our COVID experiences

Be prepared for future COVID-19 waves

Outstanding care for people in ways which matter to them

DCH Tests	We retained our resilience to deal with Covid (waves and endemic)	We did everything we could to minimise harm to patients	We delivered time-critical elective activity prioritised on clinical need	The innovation and improvements we made were retained, refined and rolled-out	We included everyone and worked together with kindness	We are providing more effective, efficient and quality care	We addressed health inequalities & recognised our role as an anchor institution

	Area	Priority 1 - Critical	Priority 2 - Urgent	Key Metric/Measure
Safe, Effective, Response	Cancer	- Full operation of all cancer services	- Endoscopy access	-Reduced no. waiting for cancer diagnostics and/or treatment ->90% previous year (PY) endoscopy
	Non-elective/Urgent Care	- ED Capacity - Improving Flow - Winter Plan	- Minimise return of minors - Discharge to Assess - Stroke rehab to community	- ED 4 Hours - <80% PY minors/type 3 - Bed Occupancy
	Elective and diagnostics	- Most clinically urgent - Minimise 52 Week Waiters	- Orthopaedics - Ophthalmology - Oral surgery - MaxFacs - Audiology - Virtual Outpatients	->90% PY overnight elective and outpatient /day case procedures - >90% PY MRI/CT - >100% PY for first O/P and FU - Total no. 52 Week Waiters - >25% All O/P Virtual, 60% of F/Us
	Secure Covid Management	- IPC Measures - Critical Care capacity and flexibility	- National Patient Safety requirements - Testing Capacity and Capability	- No Nosocomial transmission - < 85% CC occupancy & ICNARC data
Well-led, Caring	Staff and Workforce	- Workforce Planning and Recruitment - Flu vaccination	- Diversity & Inclusion - Staff Well-being	-Staff satisfaction, agency spend -Flu vaccination %
	Supporting delivery and planning for the future	- Strategic Plan - Health Inequalities - Estates & Project Management capacity - Masterplan & ED ICU Hub SOC	- Demand and Capacity Capability - Social Value - Quality Improvement - Digital Strategy	- Delivery of key strategies and plans by end of f/y
	Finance	- Financial Plan	- Reinstating non-NHS income	- Year end position

Risk Appetite, Board Assurance Framework and Corporate Risk Register

NHSEI Phase 3	Near-normal levels of non-covid health services	Prep for Winter and potential Covid spikes	Supporting staff, acting on inequalities & prevention

DCH Values	Integrity	Respect	Teamwork	Excellence

DCH 2020/21 Priorities

- These are the DCH Priorities for the remainder of 2020/21
- The framework has been developed from the NHSEI ‘Phase 3’ Letter and the Dorset ‘ICS’ Priorities but is not intended to replicate these exactly
- Absence from this framework does not indicate that other DCH services, programmes and initiatives are unimportant or that they should cease or will not be supported
- The framework should be used to help inform decisions and the allocation of resources and time
- Quality, patient experience, and staff well-being and engagement, must underpin all the work delivered to meet these priorities

Outstanding care for people in ways which matter to them

Title of Meeting	**Board of Directors**
Date of Meeting	**30 September 2020**
Report Title	**Winter Plan 2020/21**
Author	Andy Miller, Deputy Divisional Manager, Urgent & Integrated Care
Responsible Executive	Inese Robotham, Chief Operating Officer

Purpose of Report (e.g. for decision, information)

To present the Winter Plan for 2020/21.

Summary

The Operational Resilience and Capacity Plan (Winter 2020/21) describes the management of hospital flow and related functions during the winter period 2020/21. In summary the plan provides:-

- schemes to support operations for winter 2020/21 (section 3)
- hospital capacity management/emergency department escalation (section 4/Appendix 1)
- system escalation (section 5)
- an overview of the Home First Programme deliverables for winter 2020/21 (section 6.1)
- key risks and mitigations (section 7))
- core and escalated bed base (Appendix 2)
- response to severe pressure (Appendix 3)

The winter plan cross references to the COVID19 surge plans, particularly for ward escalation and capacity for ED and critical care in the expectation that a COVID19 surge may occur during the winter period.

The winter plan for 2020/21 has been informed by feedback received from key clinical and non-clinical staff from within the hospital, a series of system wide meetings and an incident management exercise.

The key schemes (section 3) summarises a plan to establish Evershot as an inpatient ward during the winter/easter period to help manage the level of admissions and acuity. The Trust does not have any capacity to flex into escalation beds as per previous years (winter plan Appendix 2) due to the re-provisioning of escalation beds into ward establishments and the conversion of Maud Alex/CCU into critical care capacity. It is anticipated that other schemes, including the Home First Programme, will create benefits to reduce the need to establish additional bed capacity, however, there is a risk that there may not be enough interim care capacity available consistently. In addition, establishing Evershot as a winter ward would provide a decant area in the event of a COVID19 surge or for other seasonal illnesses e.g. flu.

It is planned for Evershot to be used as an escalation area through the winter period. Both consultant team and ward manager are already in place. Recruitment of nursing would be

achieved by over-establishing posts in Division A (25 WTE), through a mixture of substantive and fixed term posts, bank and block booked agency filling gaps. The risk of over-recruiting would be mitigated by relocating nurses into other specialties after the winter period to fill vacant posts. A communications plan is in the process of being established/implemented.
Paper Previously Reviewed By Inese Robotham, Chief Operating Officer SMT, 16 September 2020 Finance and Performance Committee, 22 September 2020
Strategic Impact The winter plan links closely to all strategic objectives of the Trust. There is increased emphasis on collaboration with partners to create an improved system plan particularly in respect of COVID19, best use of resources and the need to improve patient flow through the hospital.
Risk Evaluation There are high risk components of the plan, in particular ensuring sufficient inpatient bed capacity, the safety of patients in emergency and urgent care services, optimising patient flow, impact of elective performance, managing staffing and the cancer standard. The purpose of the plan is to put controls in place to ensure these risks are managed throughout periods of pressure.
Impact on Care Quality Commission Registration and/or Clinical Quality The plan seeks to set enable improvements to clinical quality including the divisional/care group level OPEL trigger plans, escalation process for beds, staffing, schemes for winter and arrangements to support patient flow
Governance Implications (legal, clinical, equality and diversity or other): The plan sets out governance arrangements as part of the winter period, and beyond where applicable.
Financial Implications The Trust has not received a commitment of winter funding for 2020/21, which in previous years would have part-funded the opening of Evershot as a winter ward. The cost of opening Evershot as a winter ward for 5 months, based on agency staffing, and therefore a worse-case scenario, is in the region of £489k. A plan for consultant cover and B7 Ward Sister are already in place at no additional cost (not included in the £489k).

Freedom of Information Implications – can the report be published?	Yes

Recommendations	On the recommendation of the Finance and Performance Committee, the Board of Directors is asked to: a) Review and approve Operational Resilience and Capacity Plan (Winter 2020/21) and plan for funding key winter schemes. b) Agree to establish Evershot Ward as a winter ward for 2020/21

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

OPERATIONAL RESILIENCE AND CAPACITY PLAN (WINTER) 2020/21

SEPTEMBER 2020

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

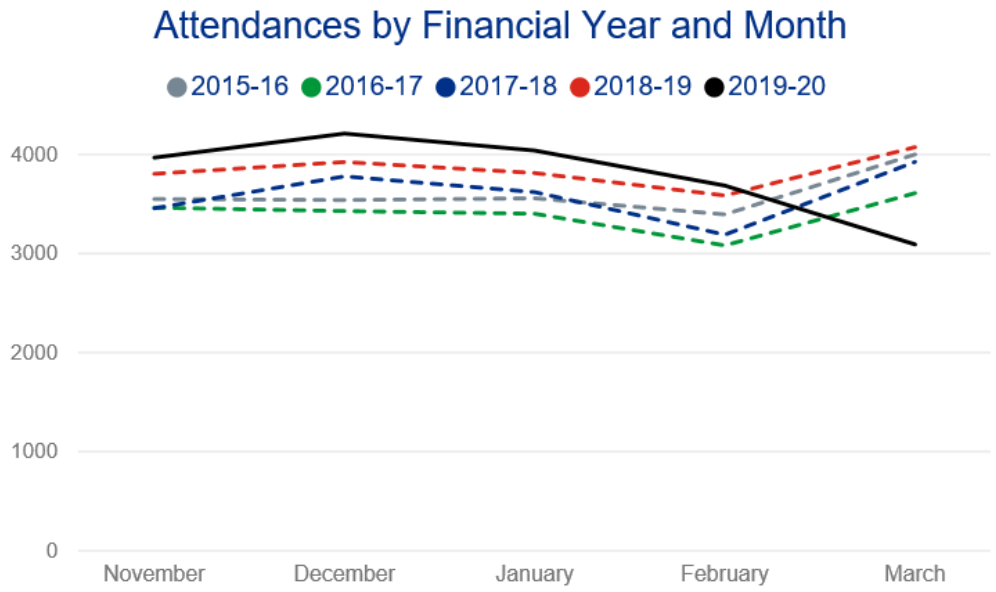
OPERATIONAL PRESSURE ESCALATION FRAMEWORK 2019/20

TABLE OF CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Winter typically results in an increase in demand both from seasonally affected conditions and increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza.

1.2 Emphasis for this winter is in ensuring increased winter activity and associated levels of acuity can be managed alongside the risk of a COVID19 surge. Fundamental to this is our ability to maintain essential emergency care services and ensure our patients and staff remain safe.



1.3 Our actions this winter are focused on planning and implementing strategies which may only be achieved by delivering our services differently and in collaboration with our partners across Dorset.

1.4 Key actions:

- Increase inpatient bed capacity by establishing a winter escalation ward
- Optimise flow out of the Emergency Department by extending core services including Same Day Emergency Care (SDEC)
- Elective plans to focus on cancer and urgent cases during times of pressure
- A workforce plan to manage vacancies and increased unplanned sickness due to COVID19 and 'winter' illnesses such as flu and norovirus
- Increasing capacity for Critical Care
- Transferring therapy and social care assessments form the wards into patients homes
- Delivery of the Home First Programme, to enable patients to return home more quickly with increased community support

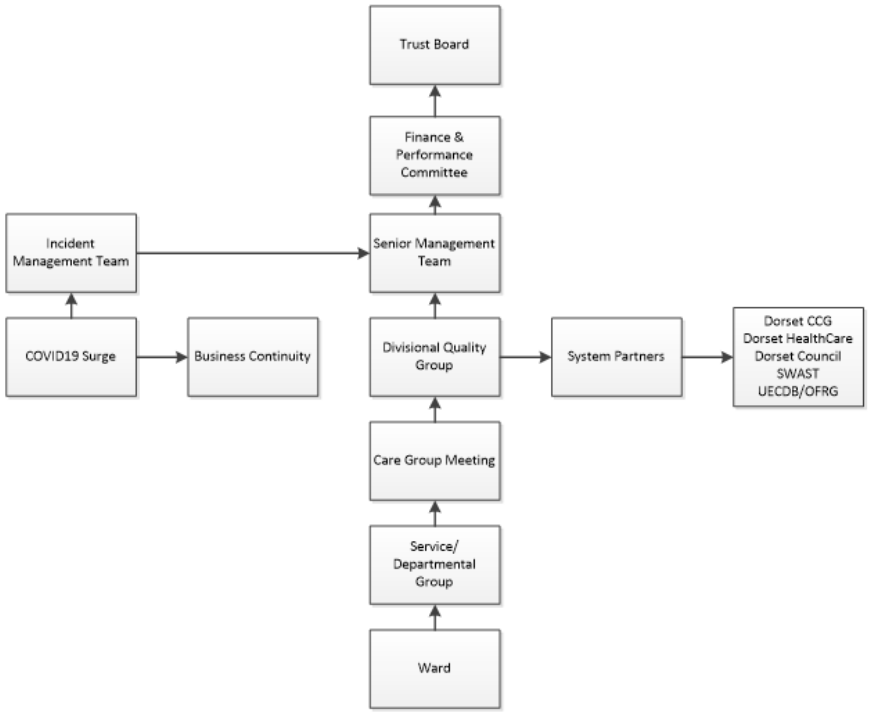
1.5 The winter plan for 2020/21 has been informed by feedback received from key clinical and non-clinical staff from within the hospital, a series of system wide meetings and incident management exercises. The winter plan will undergo testing, prior to winter, alongside the response to COVID 19 surge and escalation plans to ensure it is robust and effective.

2.0. RESPONSIBILITIES

2.1 This Plan identifies the corporate and technical strategy for operational management when capacity is predicted to fall short of demand. **All staff without exception** has a shared responsibility to ensure that at times of heightened emergency activity, patient safety is not compromised.

2.2 Responsibilities of staff in relation to this plan are outlined in this document and through business continuity plans.

2.3 The governance process for communication and monitoring of the in winter plan is:-



3. WINTER SCHEMES

The following outlines key schemes to be in place for winter 2020/21.

Scheme	Objectives	Timescale for Implementation	Partners Leading/Involved	Level of Impact (Safety, Patient Experience, Operational)	Expected Benefits	Performance Impact
Additional Inpatient / Decant Capacity	Establish Evershot Ward as a 14-bedded inpatient unit For winter activity or as an area for decant for COVID19/seasonal illness	1 December 2020 – 30 April 2021	-	High	• Additional capacity required to support flow over winter • Escalation capacity to restore bed base following overall loss of beds • Increases capacity and options for isolation of patients in the event of a COVID19 surge/IPC • Reduce the risk of outlying medical patients into surgical beds	• ED 4 Hour performance standard • Reducing the risk in of crowding in ED (RCEM Guidance) • Improvement in ED time to assessment
ED Triage	Fast Assessment Triage though modular unit (outside ED)	November 2020		High	• Reduce the risk of crowding in ED/corridor care • Enable reduced patient waiting in the department • Improved space for majors patients/resus and COVID19 symptomatic patients • Maximise use of capacity in the community	• Maintain ambulance handover performance • Resilience for COVID19 patients

Stroke & Neurology Rehabilitation	Relocating stroke and neurology rehabilitation to Yeatman Community Hospital (10 beds)	1 August 2020 – 31 March 2021	Dorset HealthCare	High	• Release capacity to support bed base over the winter • Continued specialist rehab outside of an acute hospital setting • Compliant with Hospital Discharge Standards (Discharge to Assess Pathway 2) • Improved pathway and joined up services with Dorset Stroke and Neuro Service (joint evaluation)	• Sustain high performance for SSNAP Domains 1-3 (A-B) • LoS reduction for Stroke patients
Supporting flow from the Emergency Department	Extending same Day Emergency Care (SDEC) to midnight, Monday - Friday	December 2020		High	• 'Pull approach' from ED and receiving area for GP referrals will release capacity from ED • Improve patient flow by reducing inpatient admissions • Maximising skills and resources across the Trust (medicine and surgery) • Improved experience for patients	• Support achievement of the ED 4 hour standard • Reduced bed occupancy
Improving Discharge to Assess (Pathway 1 – Home with Health or Social Care Support)	Transferring therapy and social care assessments from hospital to patients' home	Phased from August 2020 with extension across specialties to be planned	Dorset Health Care, Dorset Council	High	• Focus on older people returning home more quickly (non-specialist rehab) • Reduce risk caused by keeping patients in hospital beyond their 'reason to reside' date • Maintain support for	• Reduce Length of stay • Reduced bed occupancy

Implementation of Mental Health Core 24 Model	24/7 support for patients (adults and children) requiring mental health support	In place from August, full model to be in place from September 2020	Dorset HealthCare	High	recovery and assessment at home, not in an acute bed • Reduce the risk of vulnerable patients waiting for appropriate bed/support outside of hospital • Improved management and treatment of patients around the clock • Reduce the risk of additional staffing / security for patients	• Reduce risk of 12 breaches • Improve time waiting in the department for complex patiients

4. CAPACITY MANAGEMENT

4.1 Emergency Department (ED) Escalation

Urgent plans have been enacted to mitigate the risks following the emergence of COVID19. This has enabled the department to increase space and staffing through the:-

- relocation of minor injuries
- acceleration of planned improvements to ED, including the modular triage unit

This has led to increased capacity within the department to (winter 2020/21) and has mitigated, to an extent, previous risks for ED crowding and corridor care.

ED Capacity

Capacity	**Winter 2019/20**	**Winter 2020/21**
Resus	2	5
Majors	8	16
Fit to Sit*	0	8

*This area can accommodate for 4 trollies if necessary

In light of these changes the ED escalation plan has been updated with further action plans in support of redirecting patients, admission avoidance, rapid review of patients and specialty referral escalation (Appendix 1)

Emergency Department Escalation Plan			
GREEN - Business as Usual	**AMBER - Early Escalation**	**RED - Safety Concerns**	**BLACK - Sustained Safety Concern**
Majors A– Less than 7 trolleys in use Majors B– Less than 6 trolleys in use Majors W/R – Less than 5 chairs in use Minors W/R – Less than 5 chairs in use No ambulances waiting Triage less than 15 minute wait	Majors A– 8 trolleys in use Majors B– 7 trolleys in use Majors W/R – 6-7 chairs in use Minors W/R – 7 chairs in use If more Ambulances than capacity expected to department Triage more than 15 minute wait	Majors A– 9 or more trolleys in use Majors B – 8 or more trolleys in use Majors W/R – 7-8 chairs in use Minors W/R – 7-8 chairs in use Delay in Ambulances off loading	Social Distancing Compromised
Who Do I Escalate To?	**Who Do I Escalate To?**	**Who Do I Escalate To?**	**Who Do I Escalate To?**
Regular communication with ED Matron Bleep 828/CSM Bleep 500	Ensure Internal Escalation Protocol has been followed	See ED Internal Escalation Plan	CSM ICC – 3219 Hospital Commander ICC - 4191 Medical Commander ICC - 5177 Nurse Commander ICC - 5199 Operations Commander ICC - 5151 Support Services Commander ICC – 5133
Consider Following Actions:	**Consider Following Actions:**	**Consider Following Actions:**	**Consider Following Actions:**
No further actions	Open Triage 2 & Send staff to Minors Ensure all available transfers have been completed Patients to be spaced in waiting room Patients are transferred to SDEC and EDAU where possible	Queue patients ensuring 2 metre apart to ensure social distancing Advise ambulance service of potential delays Advise primary care and 111	Trauma and ambulance divert if appropriate

Further supportive plans are in place through 'Winter Schemes' particularly the planned extension of Same Day Emergency Care (SDEC).

4.2 Inpatient Ward Capacity

All escalation beds used in previous years are now part of the substantive ward bed base, where available, and are being used to offset the loss of inpatient beds due to COVID19 social distancing requirements and extension of critical care capacity.

The comparative inpatient bed base for winter 2019/20 and 2020/21 is shown in Appendix 2. The risk of insufficient escalation beds for winter 2020/21 is mitigated through the planned opening of Evershot Ward as a 14-bed inpatient unit.

4.3 Critical Care

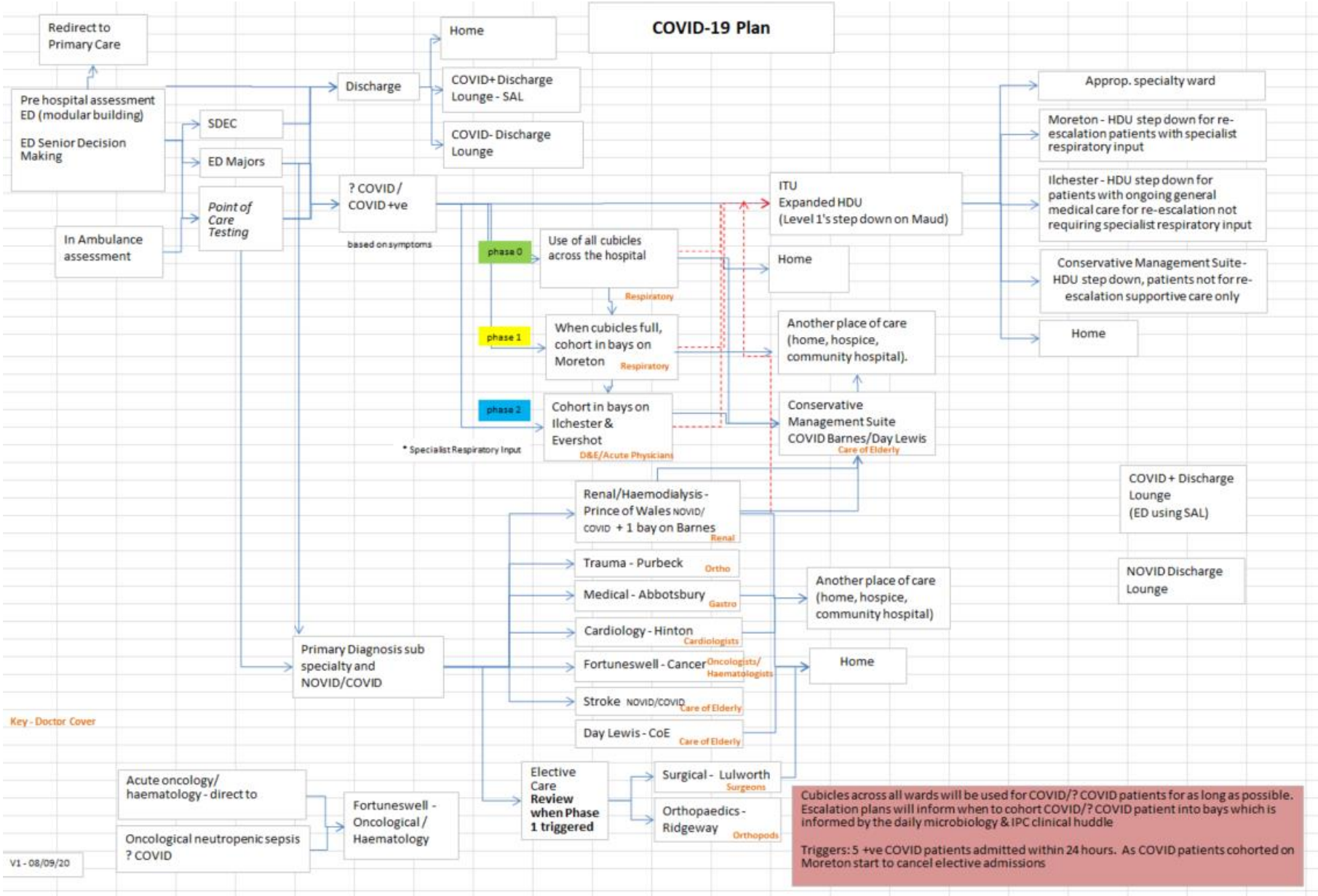
Critical Care will be able to provide care to a maximum of 25 patients.
Due to the space available within each area, bed spaces will need to be sacrificed for equipment and the provision of complex care to deliver Level 3 care

Area	Max Level 2 Beds	Max Level 3 Beds
ICU	5	5
Side rooms	2	2
CCU	6	4
HDU	4	2
Maud Alex	8	4
Total	**25**	**17**

4.4 COVID19 Inpatient Surge Plan

A plan has been established to manage the isolation of patients who are admitted with COVID19 symptoms. The plan retains specialist wards to ensure non-elective patients continue to receive the highest quality of care in the right place. Additional capacity for COVID19 patients (including symptomatic patients) has been created by reducing elective care bed capacity, particularly elective surgical and orthopaedic pathways.

The decision to enact the COVID19 Inpatient Surge Plan would be triggered by the Trusts' Incident Management Team (IMT).


COVID-19 Plan
Redirect to Primary Care
Pre hospital assessment ED (modular building)
ED Senior Decision Making
In Ambulance assessment
SDEC
ED Majors
Point of Care Testing
Discharge
Home
COVID+ Discharge Lounge - SAL
COVID- Discharge Lounge
? COVID / COVID +ve
based on symptoms
phase 0
Use of all cubicles across the hospital
Respiratory
phase 1
When cubicles full, cohort in bays on Moreton
Respiratory
phase 2
Cohort in bays on Ilchester & Evershot
D&E/Acute Physicians
* Specialist Respiratory Input
ITU
Expanded HDU
(Level 1's step down on Maud)
Home
Another place of care (home, hospice, community hospital).
Conservative Management Suite COVID Barnes/Day Lewis
Care of Elderly
Approp. specialty ward
Moreton - HDU step down for re-escalation patients with specialist respiratory input
Ilchester - HDU step down for patients with ongoing general medical care for re-escalation not requiring specialist respiratory input
Conservative Management Suite - HDU step down, patients not for re-escalation supportive care only
Home
COVID + Discharge Lounge (ED using SAL)
NOVID Discharge Lounge
Renal/Haemodialysis - Prince of Wales NOVID/COVID + 1 bay on Barnes
Renal
Trauma - Purbeck
Ortho
Medical - Abbotsbury
Gastro
Cardiology - Hinton
Cardiologists
Fortuneswell - Cancer
Oncologists/ Haematologists
Stroke NOVID/COVID
Care of Elderly
Day Lewis - CoE
Care of Elderly
Another place of care (home, hospice, community hospital)
Home
Primary Diagnosis sub specialty and NOVID/COVID
Key - Doctor Cover
Acute oncology/ haematology - direct to
Oncological neutropenic sepsis ? COVID
Fortuneswell - Oncological / Haematology
Elective Care Review when Phase 1 triggered
Surgical - Lulworth
Surgeons
Orthopaedics - Ridgeway
Orthopods
Cubicles across all wards will be used for COVID/? COVID patients for as long as possible. Escalation plans will inform when to cohort COVID/? COVID patient into bays which is informed by the daily microbiology & IPC clinical huddle
Triggers: 5 +ve COVID patients admitted within 24 hours. As COVID patients cohorted on Moreton start to cancel elective admissions
V1 - 08/09/20

4.5 Ward Staffing Plan

Provision of ward staff, sufficient to support quality of care and discharge planning focus is a key strand of the 2020/21 Winter Plan.

Current vacancies (from ESR) across the Trust (Wards) equate to 10 nurses and in the region of 31 health care assistants in order to achieve compliant rosters; this need reduces as vacancies are filled through normal recruitment.

The following strategies are being undertaken to support staffing of inpatient wards:

- Both divisions are actively recruiting to fill substantive vacant posts (including international recruitment), working closely with executive directors and recruitment to review temporary and over recruitment requirement for escalated bed areas, changes in layout due to IPC measures and to mitigate predicted gaps due to co-vid risks, maternity, and sickness.
    - 13 International nurses are due to arrive by end of November and a further 10 by January
    - Rolling RN and HCA adverts and RN social media campaign for permanent, fixed term and bank staff
    - Targeted ED nursing recruitment campaign planned for October
    - Approaching all bank staff to encourage them to consider a fixed term contract for the winter (including allocate on a arrival) or to transfer to permanent hours
- Forward planning of rosters, 2 months in advance, is already in place.
- Use of bank and low cost agencies and use of flexible/work life balance staff, including block booking, are the default to cover gaps and are being efficiently and effectively deployed to
    - support normal bed base
    - provide additional cover for sickness and other absence.
    - escalation area needs
- Monthly roster clinics to support ward processes and ensure leave is spread across all weeks and gaps are proactively filled.
- Diverting clinical and theatre staff from theatre list cancellations to undertake additional clinics and ward rounds. To support and expedite earlier discharge and provide ward support.
- Assessment of education / study leave based on pressures and known staffing levels
- Plan for additional junior doctor cover, particularly post bank holidays and in support of areas where capacity is escalated
- Flexible working utilising and upskilling teams to provide support where needed

4.6 Elective Pacing

All non-urgent inpatient elective surgery will stop from Thursday 24th of December until Sunday 3rd January.

From 4th January 2020, non-urgent inpatient elective surgery will be phased in to build up to normal levels of activity from the 18th January 2020. Phasing will be specific to accommodate individual requirements and will be based on plans at the time.

The Trust will continue with day case and 0 length of stay as appropriate.

The above arrangements do not apply to BMI Winterbourne, subject to extension of the national contract. Elective activity will continue through the winter period.

4.7 Pathology

The emergence of the COVID19 pandemic has introduced new pressures for pathology which has seen a significant increase in demand to the rapid processing and reporting of COVID19 swabs.

Availability of rapid testing at local labs is increasing with the expectation that, over winter 2020/21, rapid point of care testing will be available in-house to help with the demand and reduce waiting times for results which are required to support diagnosis, review the use of isolation and enable discharge where care is required.

Average Demand per day: 83 per day (May – July 2020)

	Model	In Place From	Maximum Number of Tests per Day	Availability	Turnaround Time (from swab to result)
Point of Care Testing (ED)*	Samba II	September 2020	36-48	7 days per week	90 Minutes
DCH In-House Testing*	GeneXpert	Now	30 (average)	7 days per week	3-4 Hours
External Testing (PHE Bristol or Porton Down)	-	Now	Undefined	7 days per week	12-14 Hours

*Manufacturers of Samba II and the GeneXpert are both developing a combined Flu/Covid test kit.

4.8 Maternity

In the event that increasing demand may increase the risk of closure of the Maternity Department at DCH, the Maternity Lead will arrange a resilience meeting with departments from neighbouring Trusts, Poole General Hospital, Yeovil District Hospital, Royal Devon & Exeter General Hospital and Salisbury District Hospital to discuss operational and patient safety risks, agree a plan for the following 24 hours and set a timescale for review. DCH may offer reciprocal support to other Trusts' who may be in a similar position.

4.8 Bank Holiday Arrangements

The divisional staffing plans for the bank holiday period will be submitted by 1st December 2020 and held by operational teams for reference. A copy will be held centrally on SharePoint for wider reference.

Emphasis is placed on managing annual leave requests, in line with Trust policy, to ensure core services are adequately covered, with expected periods of increased activity around the Christmas and New Year period.

4.9 Outbreak Plans

The Infection Prevention and Control Team (IPCT) will continue to maintain daily ward rounds and will assess patients with known infections accordingly.

Outbreaks will be managed by the Infection Control Team in close co-operation with the operational and clinical site management teams in line with national and local policy.

Information relating to COVID19 prevalence in hospital will continue to be fed through the hospital Incident Management Team (IMT) structure. The COVID19 outbreak plan is available on the Trusts' SharePoint site:-

http://sharepointapps/clinguide/CG%20docs1/2005-COVID-19-Outbreak-policy.pdf

4.10 Extended Services

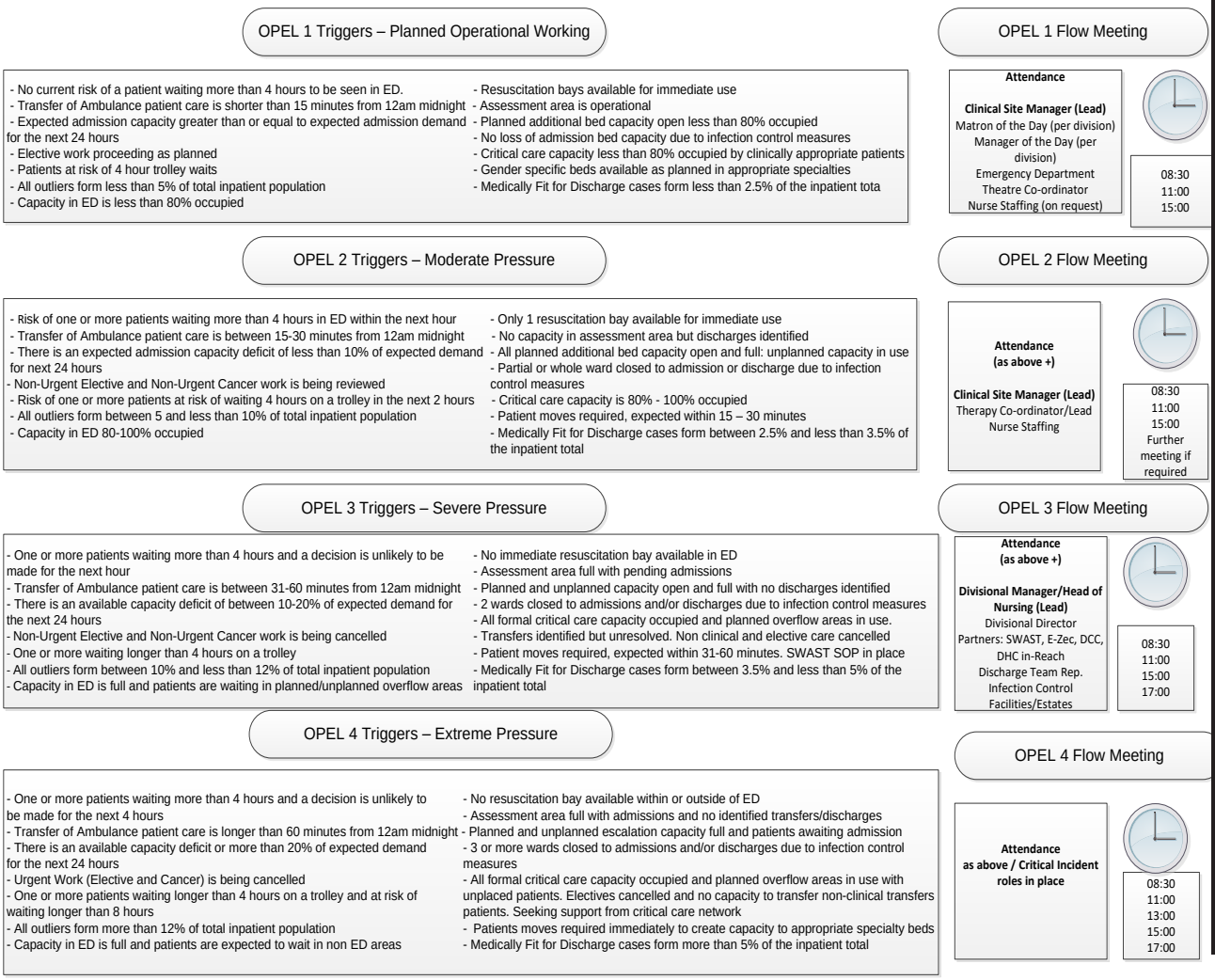
A range of operational and support services are extending or providing 7 day service cover over the winter period to enable increased flow and capacity for urgent care (Appendix 3).

5. ESCALATION

The Operational Pressure Escalation Level (OPEL) is an indicator of the operational pressure that the Trust is under and will rise and fall in a controlled manner based on prevailing and anticipated 4 levels of pressure.

The Operational Pressure Escalation Level (OPEL) is currently under review within the Dorset system following the COVID19 pandemic.

Until a revised framework is released, the Trust will continue to declare OPEL 3 when the hospital reaches a bed occupancy of 85% or higher. Actions to avoid or to mitigate operational pressure for OPEL 3 are in place (Appendix 4 – Response to Serious Pressure).



5.1 Bed/flow Management Process

The Bed Management policy supports the management and operation of the hospital site and related functions, in accordance with Operational Pressure Escalation Level (OPEL) framework.

The bed management process has been reviewed throughout the year and in response to the COVID pandemic. Changes that have been made include:-

- Revised bed meeting agenda (Appendix 5)
- COVID19 bed capacity (bedboss) report (to support surge plan in 4.4)
- Senior divisional leadership support for every bed meeting
- Internal delays highlighted through the use of the Patient Action Tracker (PAT)
- Improved process for repatriation of neurological patients (therapy triage, pre-transfer)

6. LINKS TO SYSTEM OVERVIEW

The winter plan reflects and is part of a system-wide approach to managing flow. The key metrics agreed as part of the STP incorporate bed occupancy, assessment out of hospital, ED performance are overseen by the system leadership groups.

The System Leadership Board, Health and Wellbeing Board, ICPS and Urgent and Emergency Care Board (UEC) all take responsibility for delivery of partnership arrangements to deliver flow.

Operationally, Locality Hubs will continue to support hospital discharge and assessment of patients in their own homes or in a community hospital, where patients require a period of rehabilitation prior to their return home (Appendix 6).

6.1 Home First Programme Board

The Home First Programme Board has been established to oversee the transformation of services, resources and processes to improve hospital flow (admission avoidance and hospital discharge).

The Home First Programme Board is represented by health and social care organisations across Dorset, including patient representation and primary care. The following themes have been prioritised by the system to be in place prior to the start of winter 2020/21.

- Commissioning for Discharge to Assess – increasing capacity for interim domiciliary care (pathway 1), care home beds (including dementia beds) (pathway 2/3).
- Pooling interim care capacity across organisations with a centralised approach to co-ordination, 7 days a week, using a Single Point of Access (SPA).
- Enabling assessment of patients out of hospital (acute therapy and social care), to support a 'One Team' MDT approach with Dorset HealthCare and Dorset Council

The Home First Programme Board will deliver the nationally mandated requirements of the Hospital Discharge Service: Policy and Operating Model, NHS/HM Government (August 2020).

7. COMMUNICATION

The winter plan will be shared with staff across the organisation via divisional, departmental and professional meetings for awareness and feedback. Particular emphasis will be on capacity and escalation processes, communication of information to/from flow (bed) meetings, implementation of winter schemes. Monitoring and control will be provided through:-

- Flow (bed) meetings (throughout the day)
- Divisional 'huddles' (outlined in Appendix 4)
- System resilience calls (weekly)
- Existing governance processes (risks, incidents, complaints, staff survey)

8. WINTER PLAN KEY RISKS SUMMARY

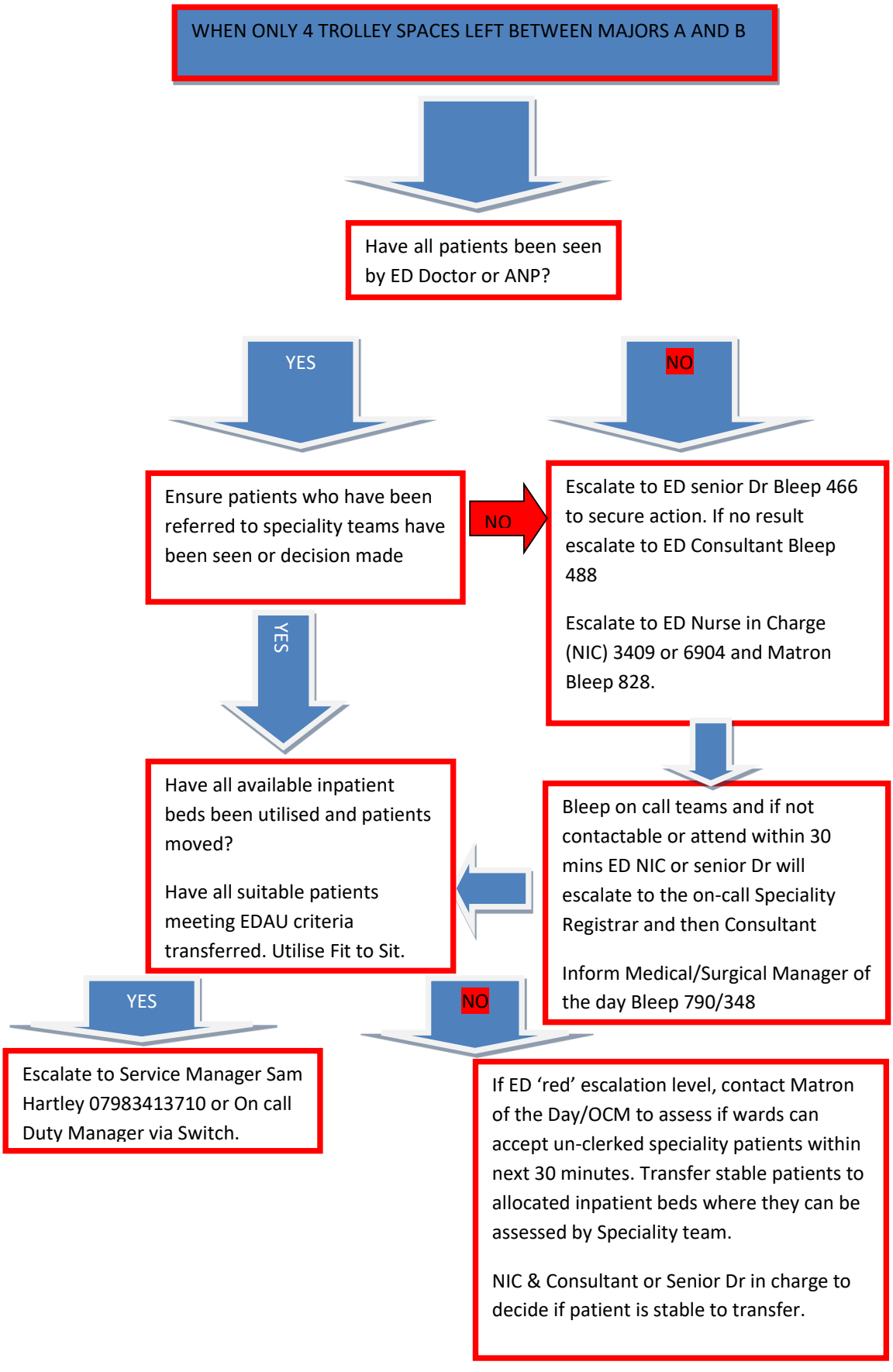
The winter plan is an iterative process, and models are in development. There remain a number of risks to service:-

Risk	Mitigation
COVID19 surge	IMT structure to enact COVID19 plan and supporting arrangements. ED, Critical Care and Ward escalation plans are in place and have been reviewed following the emergence of COVID19.
ED Estate Improvements may commence during the winter period	Estate plan to be phased. Options for the build will be planned alongside clinicians and decant areas identified. Risk and mitigations to ensure the department is able to remain safe and fully functional to be in place
Admission numbers continue to grow & outstrip bed capacity (limited escalation capacity to extend bed base)	Same Day Emergency Care (SDEC) and assessment beds are protected going into the night. Increased out of hospital support through Agincare and Acute Hospital at Home. Winter schemes and Home First programme to deliver improvements to reduce length of stay/increase out of hospital capacity to support flow.
High numbers of patients who do not meet the reason to reside criteria	Instigate OPEL 3 Serious Pressure Response Actions (Appendix 4). Home First delivery group to implement 'quick-wins for winter 2020/21 (6.1). Additional support through managing patient choice. Operational teams to review and respond to internal delays highlighted in the Patient Action Tracker.
System-wide failure pushes pressures from neighbouring acute trusts	Joint working through system wide UEC Board and supporting action plans across the system through the ICS as well as support from CCG for resilience calls and actions. Escalation plan includes triggers for escalation through Divisions to Executive and then System discussions up to and including closure of ED to new presentations.
Overcrowding in ED	ED footprint and staffing increased. Full ED escalation plan in place for support.
Seasonal flu	Ensure 75% uptake of vaccine for staff. Respond to national guidance relating to pandemic arrangements (see separate guidance) Ensure all frontline staff are trained in the use of Personal Protective Equipment (PPE). Escalate

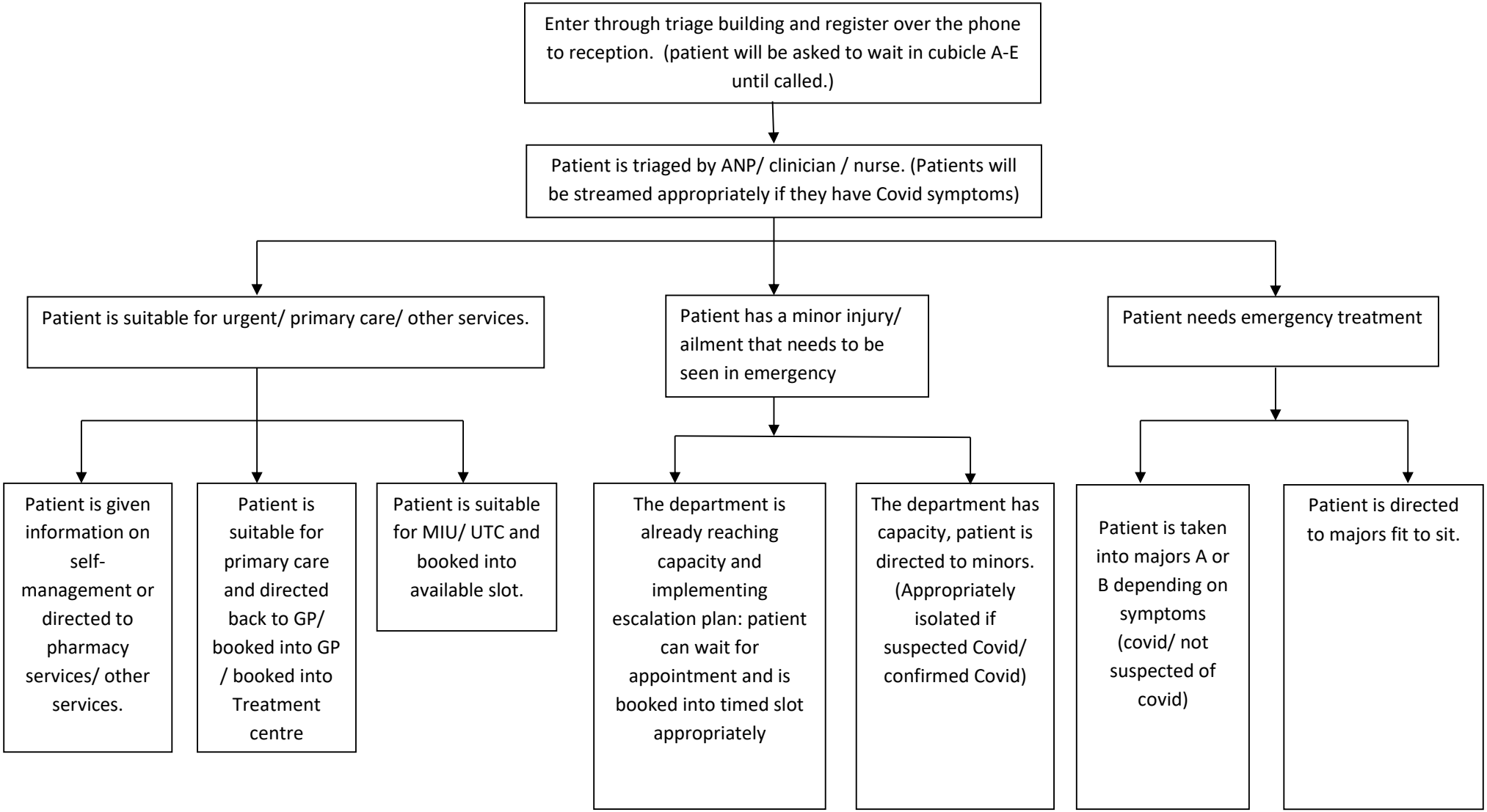
	to COVID19 / Flu Policy as directed by PHE. Risk assessment of patients in ED remains crucial for admission avoidance.
Norovirus	IPCT will re-enforce infection control practice to inform clinical staff in the lead up to winter. Daily ward rounds and monitoring for increased incidence of loose stools will continue. Direct communication from CCG/PHE and neighbouring trusts will be shared for awareness and appropriate action by DCHFT. The Trust will work with providers to prevent the risk of infection to community hospitals and care homes.
Severe weather	Review local business continuity plans for staff and communicate plans in line with national guidance on expected weather conditions. Include weather warnings in bed meetings where appropriate.
Workforce availability	HR will support operational teams with management of sudden sickness and access to temporary staffing. Planning of agency and locum clinicians will include planning for gaps arising from vacancies, planned absence and sickness, including forecast gaps arising from a COIVID19 surge

Appendix 1 – ED Escalation, Flow & Crowding Prevention Plan

EMERGENCY DEPARTMENT INTERNAL ESCALATION



Department flow: self-presenting patients



ED Crowding Prevention and Flow Improvement Plan

Think 111 first	Patients encouraged to book into emergency departments through 111 unless a life threatening condition.	System talks to implement a suitable service that fits the need of the region by 31st October.	111 able to book into all primary/ urgent and emergency pathways
Triage to correct service	All self-presenting patients will be triaged to the correct service/ department	System talks for primary/ urgent and emergency care providers to book into other services by December	
Bookable ED	Bookable slots to manage both internal and external bookings to prevent crowding	System talks for primary/ urgent and emergency care providers to book into other services by December	
Priority admissions unit	Area for priority patients to wait in a comfortable place while receiving direct supervision while waiting for a bed	National initiative to ensure crowding in ED is minimal and maintain hospital flow during times of high pressure	
E triage system	Self-check in / triage solution to ensure that patients are triaged in order of urgency	Improve flow through triage building and prioritise specific conditions	

Appendix 2 – Core and Escalated Bed Base

	Winter 2019/20		Winter 2020/21*	
Ward	**Core Bed Base**	**Unfunded escalation beds available**	**Core bed base**	**Unfunded escalation beds available**
Inpatient				
Ilchester (Acute Medicine)	25	8	30	0
Hinton/IPEC (Cardiology)	0	6 (from 01/20,18 from 02/20)	17	0
Prince of Wales (Ren	13	2	11	2 (with an impact on dialysis)
Barnes	23	0	20	0
Day Lewis	23	0	21	0
Moreton	23	0	23	0
Fortuneswell	14	3	17	0
Stroke	18	2	22	0
Maud Alex/CCU	10+6	0	12+4~	0
Ridgeway	21	4	28	0
Purbeck	27	0	23	0
Lulworth	31	0	27	0
Abbotsbury	24	0	28	0
Surgical Assessment Unit	4	0	0	0
Evershot		MED/SDEC	0	14*
Inpatient Total	262	25-37	283	16*
Day Case				
Medical Day Unit	12	0	12	0
Ambulatory Emergency Care/ Same Day Emergency Care (SDEC)	12	0	12	0
Community				
Acute Hospital at Home	15	0	15	0
Day Case & Community Total	39	0	39	0
Children				
Maternity	-	-	32	0
Kingfisher	-	-	12	0
Special Care Baby Unit (SCBU)	-	-	9	0
Children Total	-	-	53	0
Total (excluding Children)	**338 (Maximum)**		**338 (Maximum) ~ To be used flexibly for critical care/emergency surgery *Subject to funding/agreement**	

Appendix 3 – Extended/7 Day Service Support

Service	Details	Extended Days/Hours	Contact Information
Acute Hospital at Home	New referrals accepted over the weekend. Access to interim domiciliary care for patients (additional 300 hours of care over winter)	Saturday and Sunday	
Discharge MDT	Team on site over the weekend to support patients who are ready to leave hospital. 0800-1600, includes access to Social Care	0800-1600 Saturday and Sunday	discharge.team@dchft.nhs.uk ext. 3239
Infection Prevention Control (IPC)	IPC weekend support, on-call arrangement (subject to funding)	0800 – 1600 Saturday and Sunday (On-Call)	
Medical Day Unit	Extension of service to Saturday Patients that usually, freeing up weekday space to save inpatient bed activity	Saturday 09.00 – 16.00	Sister Lock ext 5749
Medical Support	Additional cavalry shift, SHO grade, to support increased activity	Monday - Friday 1700-2100 (extended hours)	Internal bleep system
Patient Transport (E-Zec)	• Additional out of hours crew for ED • Night controller to be in place for winter 2020/21	Additional crew to cover :- • Monday – Friday 2200 – 0600 • Saturday and Sunday - 24 hours	TBC
	• Dedicated support in place for out of area patient transport	TBC	TBC
Pharmacy	On-site support	Saturday & Sunday (TBC)	
Same Day Emergency Care (SDEC	Plan for extended hours of operation to reduce in-patient admissions support admission avoidance across specialities	Mon-Fri 07.30 – 00.00	Lead Advanced Nurse Practitioner Andy Norman ext 4522
Temporary Staffing	Support for temporary staffing at weekends	Saturday and Sunday 0830-1100	Staffing.enquiries@dchft.nhs.uk
Volunteers	Support to ED patients for transport booking and site management support	TBC	

Appendix 4 – Severe Pressure (OPEL 3) Response

The OPEL framework is under review, across the system, following the COVID19 pandemic. The response mandates the actions that are required at the risk of or during an OPEL 3 declaration. Currently, these actions would be triggered by a bed occupancy position of 85% or higher.

Risk Area	Actions	Lead	Timescale
Flow through ED / Crowding	Speciality in-reach into ED should be in place or speciality teams to review referred patients	ED Manager / Divisional Manager of the Day	Within 1 hour of referral
	7/9 trolley spaces are full, on either side of the department, every patient's status and need to be in ED should be reviewed. All transfers to wards, discharge lounge or home should be expedited.	ED Matron/ED Manager Divisional Matron / Manager of the Day. CSM to be informed. Escalate to OCM out of hours	Within 1 hour of trigger
	8/9 trolley spaces are full (ED Red Escalation status), **patients allocated a bed should be risk assessed with the Divisional Matron of the day with to consider immediate transfer to the ward**. This will be done with a telephone handover. Patients most suitable for the discharge lounge must be transferred to enable this.	ED Matron/ED Manager Divisional Matron / Manager of the Day. CSM to be informed.	Within 30 minutes of trigger
	When one side is completely (9/9) full, and all efforts have been made to make space, only patients with time critical needs will be unloaded from the ambulance.	ED Matron/ED Manager Divisional Matron / Manager of the Day. CSM to be informed.	Immediately
Inpatient ward Capacity	Review Patient Tracker to identify internal delays with treatment or discharge	Matron/Service Manager	Daily
	Senior attendance at board rounds to provide additional leadership and troubleshooting support	Matron/Service Manager/Heads of Therapy	Daily 08:30-09:30
	Daily Discharge MDT to be led by Matron or Service Manager to offer support and senior decision making	Discharge Matron/Service Manager	Daily 10:30-11:30
	All patients waiting for care or	Discharge MDT Co-	Daily 10:30-

	other support to be transferred to another location.	ordinator/Lead	11:30
	Escalate issues early, before 11am bed meeting Ensure all patients have been reviewed by a	Matron/Service Manager/Heads of Therapy	Daily 12:00
	Consultant to ensure each patient has a Reason to Reside status (previously medically fit) with an Estimated Date of Discharge. The EDD will be the date that the patient is expected to leave hospital.	Consultant	Daily by 1200
	Consider extending opening hours of the discharge lounge to accommodate patients waiting to go home from the ward/ED	Discharge MDT Lead/Co-ordinator	

	Senior 'huddle' to receive escalation and review and enact plans to support patient flow:-
	• ED
	• Current/forecasted bed position (divisional)
	• Escalation from matrons/managers arising from:-
	  • Board/Ward Rounds
	  • Discharge MDT Meeting
	  • Internal Waits (from Patient Tracker)
	  • Specific service issues affecting flow
		Divisional Management Team	Daily 12-12:30

Insufficient Elective Care Capacity	To review, seek approval and implement TCI cancellations for the following 24 hours	Service Manager/OCM/OCE out of hours	By 1500 bed meeting for the following day
	Ensure there is capacity to accommodate the expected emergency demand, for each specialty, for the next 24 hours as part of planning TCIs	Service Manager/OCM/OCE out of hours	By 1500 bed meeting for the following day
	Extend day surgery hours to accommodate additional patients	Service Manager/Day Surgery Lead	By 1500 bed meeting for the following day
Staffing	Increase block booking of agency	Divisional Matron of	Providing

	staff for the predicted duration of pressure Additional junior doctor shifts to be identified and authorised to support decision making and flow (doctors). Out of hours and weekends Assess whether staff groups are required to provide support to wards. Outpatients, Endoscopy, Theatre staff, Specialist Nurses, Matrons, Corporate Services, CPE, Day Surgery.	the Day/Divisional Head of Nursing Divisional Management Team Divisional Matron of the Day/Divisional Head of Nursing	minimum 24 hours' notice. Minimum 48 hours' notice prior to weekend
Workforce & Training	Stand-down non-essential training, supervisory commitments and meetings in support of flow activities	Divisional Matron/Manager of the Day	
Ensuring communication with all key staff	Inform Wards of OPEL level agreed at 0830 Bed Meeting (cascade via Board Round attendance to support decision making) Resilience alert to be sent to spoa.alerts@nhs.net	Matrons/Service Managers Divisional Manager of the Day/OCM out of hours	08:30 – 09:30 . By 0930
Bed Meeting	Senior leadership of bed meetings (rota in place)	Divisional Management Team (DM, HoN, DDM)	All bed meetings (08:30, 11:00, 15:00, 17:00 (by exception)
	Confirm plan for overnight at the 1500 bed meeting, including plans to use escalation areas beyond bed base (shown in Appendix 2), requiring executive approval	Divisional Management Team (DM, HoN, DDM) OCM to attend 15.00 bed meeting	All bed meetings (08:30, 11:00, 15:00, 17:00 (by exception)
	Advise On-Call Teams of Trust position	Divisional Management Team (DM, HoN, DDM)	All bed meetings (08:30, 11:00, 15:00, 17:00 (by exception)
High levels of admission (continued 65+ admission	Cancel non-essential activity to support longer ward round duration and 2nd PM board round/review. Focus on specific	Service Manager/Clinical Leads/Divisional Director OCM/OCE	Action taken within 24 hours of trigger pre-

following OPEL3 status)	specialities where pressure is expected, this may include but not limited to:- • Acute Medicine • Medicine for Older People/Frailty • General Medicine (including outliers) • Respiratory • Trauma/Orthopaedics Ensure criteria led discharge for appropriate patients in support of ward/clinical team enacting weekday and weekend discharges	out of hours Clinical Leads/Ward Sisters	emptively cancel activity for consultants and key clinicians
Core Service Support (part of or supporting inpatient wards) Diagnostics, Pathology, Endoscopy, Pharmacy, Therapy	Prioritise workload to support patient flow, cancellation of non-essential clinical commitments (e.g. clinics, routine appointments)	Service Manager/Department Leads	Daily. Arising from bed meetings and daily huddles

Appendix 5 – Bed Meeting Agenda

Bed Meeting Agenda

1. Actions from last Bed Meeting
2. ED Status including Performance and Breeches
3. Bed Status
4. Staffing
5. Doctors- Staffing Gaps
6. Theatres Including TCIs for next day's attendance
7. Paediatrics
8. Maternity
9. Urgent and Integrated Care Update including MoD feedback with actions to record
10. Family and Surgical Update including MoD feedback with actions to record
11. Reason to Reside actions
12. Partner Agencies
13. Repatriations
14. Transport
15. IPC
16. Support Services
17. Staff Welfare

All Actions to be updated at the end of each bed meeting.

Appendix 6 – Supporting Services – Locality Hubs/Community Hospitals

Community Hospital	Number of Beds	Contact
Blandford	24	01258-456541
Bridport	22 beds + 11 Escalation beds	01308-422371
Lyme Regis	5	
Shaftesbury	15	01747-851535
Sherborne	28	01935-813991
Swanage	15	01929-422282
Westhaven (Weymouth)	34	01305-786116
Wimborne	22	01202-856410

West Dorset / Bridport Hub - 01308 426286
Monday – Friday 8.30am – 6.00pm (DN cover till 8.00pm)
Saturday – Sunday 9.00am – 8.00pm (clinical out of hours)
Email: dhc.bridport.ot@nhs.net
Based at Bridport Hospital (covering Bridport Hospital)
Health & Social Care Co-ordinators:
Holly Bradbery / Kim Morfet / Harriet Morgan-Smith
GP surgeries: Tollerford practice (Maiden Newton and Beaminster), Barton house, Bridport medical centre, Portesham

Mid Dorset / Dorchester Hub - 01305 216688
Monday – Friday 8.00am – 8.00pm
Saturday – Sunday 8.00pm – 8.00pm (clinical out of hours)
Email: dhc.middorsethub@nhs.net
Based at Dorchester Local Office (covering Dorset County Hospital)
Health & Social Care Co-ordinators:
Cara Bernardini / Nicky Rhodes / Kathryn Morgan
GP Surgeries: Atrium Health Centre, Crossways Fordington, Prince of Wales, The Poundbury practice Puddletown, Cerne Abbas, Milton Abbas, Queen's Avenue

Weymouth & Portland Hub - 01305 361061
Monday – Friday 8.30am – 5.00pm
Saturday – Sunday Closed
Email: dhc.weymouth.hub@nhs.net
Based at Westhaven Hospital (covering Westhaven and Portland Hospitals)
Health & Social Care Co-ordinators:
Emma Kane/Emma Vallance
GP Surgeries: Lane House, Wyke Regis, Royal Crescent Abbotsbury Road, The Bridges, Dorchester Road, Dorchester Road, Portland, Preston Road, Cross Road

Blandford Hub - 01258 394018
Monday – Friday 8.30am – 8.00pm
Saturday – Sunday 9.00am – 5.00pm (clinical out of hours)
Email: dhc.blandford.crt@nhs.net
Based at Blandford Hospital (covering Blandford Hospital)
Health & Social Care Co-ordinators:
Andrea Trim 07721236799 / Diane Price –07717 361732,
GP Surgeries: Whitecliff Mill Street, Blandford, Eagle House, Blandford, Sturminster Newton, Blackmore Vale Partnership, Sixpenny Handley

Purbeck Hub - 01929 408073
Monday – Friday 8.00am – 8.00pm
Saturday – Sunday 8.00am – 8.00pm (clinical out of hours)
Email: dhc.purbeckhub@nhs.net
Based at Wareham Local Office
(Covering Swanage & Wareham Hospital)
Health & Social Care Co-ordinators:
Tanya Titman - 01929 557086 / Emily Gadd - 01929 557088
GP Surgeries: Swanage, Bere Regis, Corfe Castle, Adam Practice (Lytchett Matravers), Adam Practice (Upton), Sandford, Wareham Health centre, Wellbridge (Wool)

Sherborne Hub - 01935 601402
Monday – Friday 8.00am – 6.00pm
Saturday – Sunday 9.00am – 5.00pm (clinical out of hours)
dhc.sherborne.crt@nhs.net
Based at Yeatman Hospital (covering Yeatman Hospital)
Health & Social Care Co-ordinators:
Christine Noble 01305 361549 / Margaret Mcginty 01305 361549
GP Surgeries: Apples Medical Centre, Bute House Surgery, Newland Medical Practice, Yeatminster Health Centre.

Title of Meeting	Board of Directors
Date of Meeting	**30 September 2020**
Report Title	**Health Inequalities**
Author	Nick Johnson, Director of Strategy, Transformation and Partnership
Responsible Executive	Patricia Miller, Chief Executive

Purpose of Report (e.g. for decision, information) For information	
Summary. As part of the NHS 'Phase 3' response to the Covid Pandemic NHS organisations have been asked to implement a number of requirements to address Health Inequalities which have been further exposed some of the health and wider inequalities that persist in our society.	
Paper Previously Reviewed By Executive Team Quality Committee, 22 September 2020	
Strategic Impact There is a close link between DCH's emerging Social Value and Anchor Institution work and Health Inequalities both of which aim to improve the health of those most at risk to reduce the need for health and care services and therefore the demand for hospital services.	
Risk Evaluation N/A	
Impact on Care Quality Commission Registration and/or Clinical Quality None arising as a result of this report. Implications of any specific actions will be considered by appropriate governance on a case by case basis.	
Governance Implications (legal, clinical, equality and diversity or other): None arising as a result of this report. Implications of any specific actions will be considered by appropriate governance on a case by case basis.	
Financial Implications. None arising as a result of this report. Implications of any specific actions will be considered by appropriate governance on a case by case basis.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board: • Notes and comments on the Health Inequalities agenda and the proposed actions and approach set out in section 3

1. Introduction

COVID-19 has shone harsh light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. COVID-19 risks further compounding inequalities which had already been widening.

It is an integral part of the third phase of the NHS response to COVID-19, as set out in the letter to the NHS on 31 July. As such, the actions set out here focus on the immediate tasks of continuing to protect those at greatest risk of COVID-19, restoring services inclusively and accelerating targeted prevention programmes, underpinned by improvements in leadership and accountability, data and insight and collaborative planning.

These measures will help lay the foundations for further action, particularly to enhance prevention and contribute to the concerted cross-governmental and societal effort needed to address the wider determinants of health; building on the strategy set out in the NHS Long Term Plan and the NHS's legal duties with regards to equality and health inequalities.

2. Requirements

COVID-19 has further exposed some of the health and wider inequalities that persist in our society. We are therefore asking you to work collaboratively with your local communities and partners to take the following eight urgent actions:

1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.
2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.
3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.
4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.

5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.
6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.
7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.
8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

3. Approach and Actions

The overarching approach must be to work across the ICS and embed Health Inequalities into health and care planning and service delivery.

The Dorset ICS has identified actions as part of the ICS Operational Plan for the remainder of 2020/21. This is attached at Appendix 1. System action will be overseen by the System Partnership Board and the System Leadership Team.

DCH has developed an Action Plan to help guide specific actions. This is attached at Appendix 2.

For DCH It is proposed that:

- An Board Level Executive is agreed and appointed
- Progress on the HI agenda is reported to the Quality Committee
- A clinical lead is appointed
- An operational lead is appointed
- A small working group is established to ensure focus
- The HI work and Social Value work are linked

4. Recommendations

The Board:

- Notes and comments on the Health Inequalities agenda and the proposed actions and approach as set out in section 3 above.

Dorset Integrated Care System

Phase 3 Recovery Plan

DRAFT V1.1

Contents

Introduction

Our Dorset Integrated Care System Recovery Plan sets out how we will recover health and care services, whilst managing the additional demand of winter pressures, whilst living alongside Covid-19 and any potential second spikes.

In line with the Third Phase of NHS Response to Covid-19 (add in hyper link) our plans reflect how we will aim to:

- return to near normal levels of non Covid-19 health services
- prepare for winter and manage any further second spikes
- lock in the beneficial changes we have already seen
- take urgent action to tackle the inequalities that exist across Dorset and those that have been exacerbated due to Covid-19
- support our staff

Our plan has been developed and informed by our system partners recognising the sovereignty of each organisation and focuses on the areas where we can ensure maximum improvements for the people of Dorset by working together. Therefore, recognising that partners will have specific priorities that they will deliver within their own organisations.

We have continued to be proactive in our communications, working collaboratively on campaigns and messages to inform the public. Working in line with national Covid-19 engagement guidance produced by NHS England and Improvement. Significant efforts have been made to maintain, and strengthen, stakeholder relationships, keeping people informed and involved, our plan sets out how we will continue this and reflect local learning from the Covid-19 insight work and the recent "Five principles for the next phase of the Covid-19 response" produced by National Voices (see page XX).

Our plan also reflects the need to continue to prevent potential outbreaks of Covid-19 and where this is not possible, minimise the spread of the infection across Dorset in line with the local Outbreak Management Plans for Dorset Council and Bournemouth, Christchurch and Poole Council.

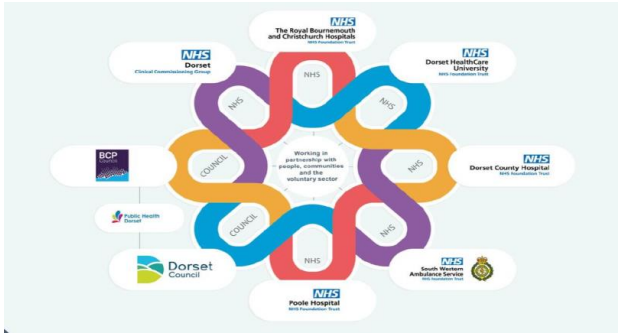
Add in additional info from Jane Horne re OMP

Our Aims:

We have set seven clear aims for recovery as follows:

- to accelerate the model for more integrated primary community and social care, including new home first pathways
- provide appropriate care for those who have not presented to mental health services during Covid -19; both current and emerging
- optimise urgent care capacity, minimising the risk to patients and staff, whilst living alongside Covid-19
- minimise the elective back log to create maximum capacity to treat and support those living with cancer
- optimise capacity to minimise the elective backlog and manage future demand
- establish sufficient, and maintain, critical care demand and service infrastructure to meet future Covid-19 demand and non Covid-19 demand
- address staff wellbeing and better collective workforce planning

Fig 1: Dorset Integrated Care System



Beneficial changes made during Covid-19 Response

During our response to Covid-19, by working collaboratively with a common purpose and drive in Dorset, we have:

We have sorted:	Digital approach using technology in support of patient care and ways of working	Improved timeliness and use of data/ intelligence	Pathway changes such as discharge, self-direct help an support, high quality clinical decision making in 1st 24hrs	Focus on staff wellbeing
We have seen:	Staff working together within teams	Clinical leadership across the system	Pace and agility of decision making	Different and more flexible roles
We now have:	Shifted to a single public service focus not just NHS	Closer collaboration across the system	A system that makes decisions based on needs and thinks pro-actively	Better communications and relations across all sectors

Dorset ICS Picture- Key Challenges to be completed activity, workforce, performance

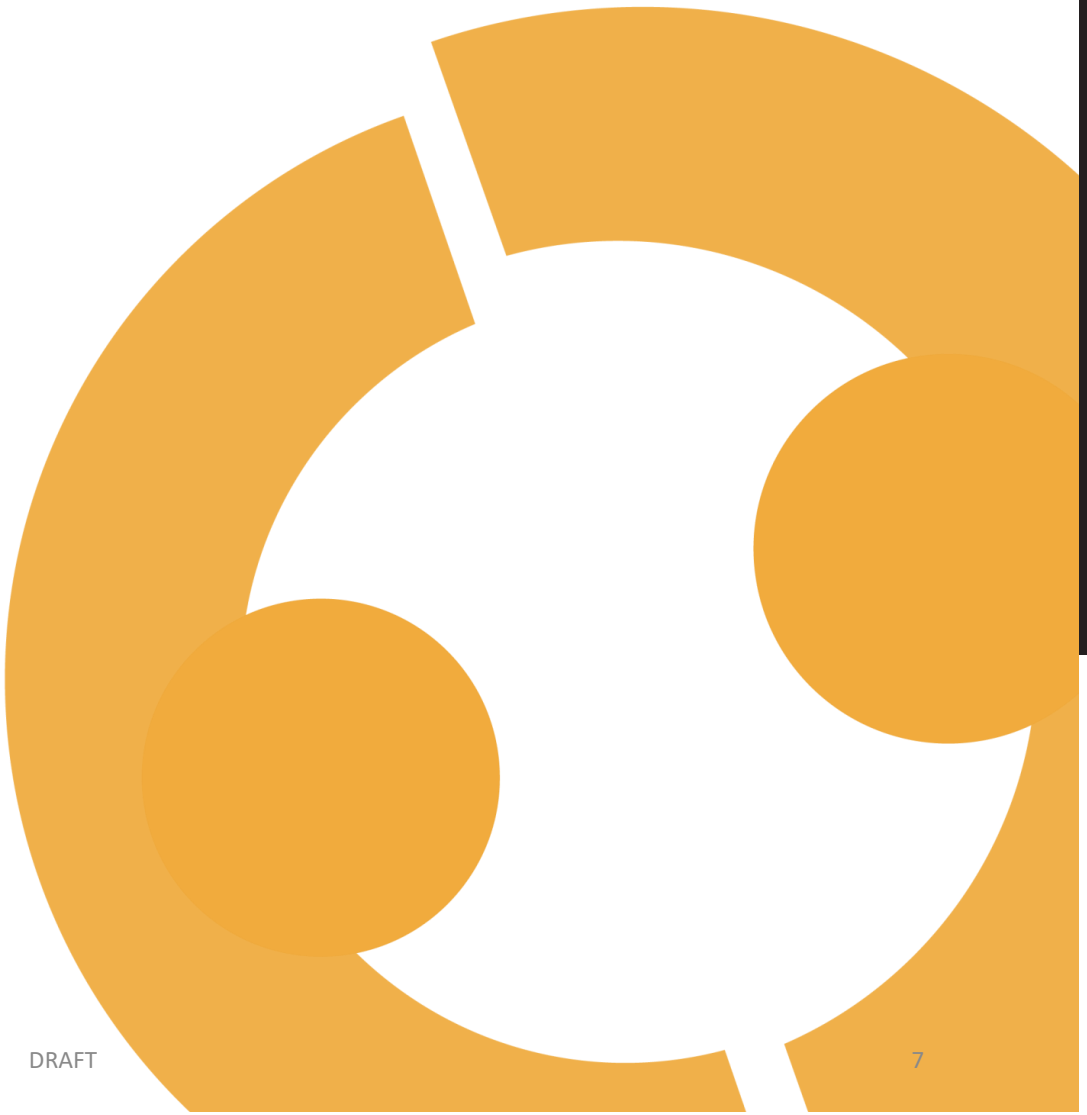
Our Plan

Dorset Integrated Care System have been working together to develop Phase 3 Recovery Plans. In doing this we have established a Health and Care Recovery Coordination Group, membership comprising of Chief Executives and Chief Operating Officers, Primary Care and CCG and Local Authority Directors of Adult and Children's Social Care. Through this group we have identified local recovery priorities, which can be seen below.

Tests	Do we understand need/demand (incl winter/second peak)?	Do we understand our capacity to deliver against the need?	Do we have plan to bridge the gap ?	Does our plan address inequalities that exist?	Have we identified risks and mitigating actions?	Have we identified comms and engagement requirements?	Do we have the right people involved ?
RECOVERY PRIORITIES							
Sector/ Area	**Priority 1- Critical**		**Priority 2- Urgent**		**Aim (links to NHSE/I 7 test)**	**Clinical Lead**	**Chief Exec and Management Lead (suggestions)**
Social care	Home First programme		Social prescribing, self care/ reliance, care homes, Long Term Condition Management, shielding		To accelerate the model for more integrated primary, community and social care, including new home first pathways	PCN clinical directors GP Clinical Leads	Eugine Yafele Jan Thurgood Vivian Broadhurst Kris Dominy Sally Sandcraft
Primary and Community Care			GP/PCNs 'Living with Covid & Business Continuity, Digital solutions				
Mental Health	IAPT, psychiatric liaison, bed capacity Children and Young People Mental Health		MH after (Covid) care, SMI health checks, homelessness, domestic violence, safeguarding, psychosis rise		To provide appropriate care for those who have not presented during Covid both current and emerging	TBC	Eugine Yafele Sally Sandcraft
Urgent Care	Optimise ED capacity, efficiency and safety. MIU pathways Strengthen 111		Alternative pathways for ambulance Same day emergency care Non –cancer latent demand		Optimise urgent care capacity, minimising the risk to patients and staff whilst whilst living alongside Covid	TBC	Patricia Miller Sue Sutton
Cancer	Latent demand Endoscopy (incl screening)		Retaining use of ISPs being used at maximum capacity		Minimise/clear the elective backlog and create maximum capacity	TBC	Debbie Fleming Cindy Shaw Fletcher
Elective care & diagnostics	52 weeks, Endoscopy		Ophthalmology, Orthopaedics, ENT, Oral Surgery (NHSE comm), Audiology		Optimise capacity to minimise the elective backlog and manage future demand	TBC	Debbie Fleming Sally Banister
Covid treatment and critical care capacity	Critical care capacity- beds, rehab, transport		Primary care Covid treatment pilot		Establish sufficient and maintain critical care demand and service infrastructure to meet future Covid-19 and non Covid demand	TBC	Richard Renaut Sally Banister
Staff wellbeing and numbers	Workforce planning Equality and Diversity		Staff health and wellbeing support, mutual aid and flexible working.		Address staff wellbeing Better collective workforce planning	Dr Forbes Watson	Emma Shipton
Dorset reset	LTP #2 -ICS operating model including financial framework, governance and oversight and assurance frameworks. Develop the new landscape and role of the role of ICSs Delivery to date, future models of care, how we will work together and he supporting governance and oversight						Tim Goodson/ Phil Richardson/ Nikki Rowland

Principles	People First	Home and community focussed	Embed quality improvement gains	Innovation through digital first	Evidence based and needs led	Proactively supporting staff	Do it once, do it at pace, do it together	Safety first

Detailed Programmes and Schemes/Initiatives as at 12 August 2020



Home First Programme

The Home First programme aims to implement an integrated Home First solution that will focus on the enablement of people to achieve their health and social care outcomes in the community which is flexible and dynamic with a rapid enough response to meet the changing needs of Dorset's population. Ensuring that people only receive acute hospital care when needed, for the period that they need it, with a swift and supported discharge home.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- discharge to assess model in place based on current resources

We have seen:

- improvements in delayed transfers of care during Covid-19, which was in part due to a reduction in demand on services

We now have:

- a Programme Board and Delivery Board established to oversee the next phase of D2A

Workstreams

During 2020/21 we will focus on the following workstreams:

- data Intelligence - develop a Home First system dashboard detailing flow within the system
- mapping of services – understanding what is currently available to support people to identify gaps and need to design future services
- acute Hospital Discharge Operational Group – managing the here and now using current infrastructure, escalating issues as required
- commissioning - support a co-ordinated approach to commissioning health and social services to meet individual's needs. To ensure compliance with procurement legislation
- Winter Task and Finish Group – set up to look at current services to identify initiatives at pace to support Winter 2020
- Therapist Review Task and Finish Group – to look at how Therapists can be utilised more efficiently to support people at home
- Additional information re D2A to be added in line with guidance received on 26/8/20 including confirmation re named discharge lead and single co-Ordinator.

We recognise the Interdependencies on other programmes will work with these programmes to ensure delivery, including:

- Health and Care Recovery Programme
- Better Care Fund
- Urgent and Emergency Care
- Primary and Community Care
    - End of Life Services
    - Enhanced Care in Care Homes

Trajectories- to be added

Investments

Further work to be undertaken to understand future funding requirements.

Programme Governance

This programme is overseen by the Home First Programme Board, with a Senior Responsible Officer and has a dedicated Programme Director

Home First - Priority Schemes /Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Discharge to Assess Model	To ensure patients are discharged swiftly from hospital with appropriate care and support, with assessments for longer term care taking place outside of hospital	Maintaining a 11% reduction in LOS	To be reviewed	Helen Persey – Dorset Healthcare	In situ	

Personal Health Commissioning (Continuing Health Care)

In line with the Phase 3 letter and subsequent 'Reintroduction of NHS continuing healthcare (NHS CHC): guidance' we are required to restart CHC assessments from 1 September 2020, in line with the following principles:

- Patients should be considered for CHC at the right time and in line with the National Framework for NHS CHC which articulate when it is appropriate to complete a checklist
- All CHC and Care Act Assessments should take place outside of hospital
- A new D2A model detailing 6 weeks of free care will apply from 01/09/2020 for all discharges where the patient has had a change in need, or to prevent a hospital admission. The application of this model will be overseen by the Home First Programme Board
- All patients discharged from hospital and identified as needing a checklist must have their checklist and DST completed before the end of the 6 week funding period. On the rare occasions that it is not completed the CCG may continue to fund the interim care
- CCGs and Local Authorities must extend the use of the Trusted Assessor Model and Digital Assessments to carry our CHC assessments.

CCG's and LA's will now have to manage 2 streams of work:

- NHS CHC work deferred between 19/03/2020 and 31/08/2020 (the C19 period); and
- Routine NHS CHC referrals, starting from 01/09/2020

The number of assessments needed under workstream 1 will become apparent over the next quarter as work is completed to identify those patients needing an assessment. Early estimates indicate c1000 assessments will be needed.

Additional resource will be needed to undertake the initial work and funding is being made available from NHSE for this, with further details of how to access this funding due shortly.

Resource will be need for Workstream 1, but also any work relating to:

- Backlog of FNC assessments (these can result in a CHC assessments)
- Appeals relating to decisions which confirm a patient is not eligible for CHC
- Disputes relating to decisions whereby the Local Authority disagree with the eligibility decision; and
- Any retrospective work needed from members of the public who should have had their funding funded under C19 and have not, or have paid for additional care whilst CHC and Care Act Assessments were paused

NHS Dorset CCG will be required to submit a data return to NHSE every 2 weeks starting from 14/09/2020 detailing progress against the outstanding work.

Integrated Community and Primary Care Services Programme

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Strengthen frailty and home visiting service
- Hot and cold primary care sites
- Alternative approaches to triaging
- Shared workforce
- Increase social prescribers

We have seen:

- Joint working between the CCG and Primary Care Network Clinical Directors and business leads

We now have:

- Clear guidance to general practice on reset and recovery which takes into account national guidance and focus on priorities for the remainder of 2020/21

Workstreams

During 2020/21 we will focus on the following workstreams:

- Reset and recovery planning for general practice, aiming for 100% reset by October 2020
- Complex care including:
    - Proactive/anticipatory care: care homes;
    - Shielding/vulnerable patients ongoing support and community response;
    - Contributing to Integrated PCC Mental Health Services' Project;
    - Link/contributing to Reactive – Community Response – Home First Programme (see page XX urgent care)
- Long Term Conditions management
- Access - PCN/general practice same day ambulatory care (urgent) linked to review of IUCS especially IAGPS (see page 20)
- Winter planning – Flu – our flu plan has been developed and shared with the region (see page 18)

Screening - backlog addressed and back to 'normal' target delivery for 2020/21

Immunisations and vaccinations - to deliver trajectories in line with previous year and nationally agreed targets for 2020/21

Inequalities - using Population Health Management (PHM) to supporting focus on reducing inequalities and addressing unwarranted variation, eg health checks and action plans for those with a learning disability and those identified as vulnerable (see page 46).

Ethnicity reporting in primary care by 1 September 2020, currently undertaking baseline assessment of records. Developed plans to capture all new registrants and those where this information is not already held.

Enabling strategies:

- Workforce including continued occupational health support and staff risk assessments colleagues with protected characteristics identified through Covid-19 pandemic
- Digital (see page 46)
- Estates
- Comms and engagement
- PHM - planning for managing Covid-19 and managing local clinical need (see page 46)

In preparing for winter and any potential second surge we have in place:

- business continuity plans and joint planning discussions across PCNs for areas where an at scale response may be required/beneficial (for example flu vaccinations and workforce mutual aid)
- Pulse Oximetry Pilot that would support a wider system approach to help manage Covid-19 related symptoms/patients in general practice both in and out of hours. This would support a potential surge or outbreaks in Dorset
- SITREP and mutual aid support not only across PCNs but also wider system
- Hot and cold sites, including capital planning
- Development of a system testing strategy that will support primary and community care
- System PPE support

Investments

All investments are detailed in table XX overleaf.

Programme Governance

This programme is overseen by the Primary Care Integration Strategy Group, with a Senior Responsible Officer and Clinical Lead. Delivery is overseen by the Deputy Director Primary and Community Care, reporting through the Director to PC Commissioning Committee and ICS System Reset & Recovery Group.

Primary and Community Care- Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
GP contract reinstating services in line with phase 3 guidance	All GP services recommenced (where safe to do so) to ensure mitigation of undue harm as a result of restricted and/or change in delivery mode to access General Practice during Covid-19	• 100% reset of services by October • Cervical screening backlog addressed and back to 'normal' target delivery for 2020/21 • Achievement of flu vaccination targets for 2020/21 • Immunisations and vaccines trajectories in line with previous year and nationally agreed targets for 2020/21 • Delivery of PCN DES 2020/21 service specifications	• GP Contract • PCN DES • IIF • CCLIP • LES • GP Covid-19 Fund	Principal Lead Primary and Community Care Team	Various timeframes however all aim to be completed by 31 March 2021	
Testing in primary care	Staff access to symptomatic and antibody testing	100% staff access to testing		Senior Programme lead Primary and Community Care Team	TBC phased approach working with Dorset testing cell and NHSE	
Care models	Ensuring access to care: • Digital and physical access to meet need as appropriate • Hot and cold sites • Care home support • Cancer diagnosis • Referrals to secondary care for elective care provision as clinically appropriate	• 100% patients with digital access • Full utilisation of Improved Access to General Practice available consultations • 100% care homes aligned with PCN's and supported by clinical teams • PCN workforce plans in place and additional roles recruited as planned	• CCLIP • PCN DES • PCN IIF Fund • Covid-19 Funding	Principal Leads Primary and Community Care	31 March 2020/21	

A detailed plan has been developed which sets out all initiatives, schemes and key performance indicators which will be used to assess progress on delivery and recovery (plan/ link to be added)

Mental Health, Learning Disabilities and Autism

We have reviewed our ambitions for 2021 aligned to achieving the aspirations for the NHS Long Term Plan requirements. The Dorset system remains committed to the Mental Health Investment Standard and investment plans are in place to support ongoing achievement through 2020/21.

Trajectories are in place to support achievement of the long-term plan milestones albeit it is acknowledged that the impact of Covid-19 has made this more challenging in specific areas.

The significant reduction in referrals to Steps to Wellbeing (IAPT) increases the risk of the service missing its access trajectory. Modelling of the Covid-19 impact suggests the service may experience a surge in demand in coming months and the system is considering the best means of managing this through allocation of additional resources.

Dedicated work has also recommenced in respect of both SMI and LD physical health checks with a renewed focus on improving the current position.

Dementia diagnosis rates have also been impacted by Covid-19 and we anticipate increased challenges beyond those already experienced in Dorset in relation to achieving the diagnosis threshold. It is envisaged that the implementation of the new Dementia Services Review model of care will go some way to improving the diagnosis rates, however implementation timescales have been delayed as a result of changes to the availability and allocation of previously identified new integrated community services transformation funding.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Digital access and IT enabled services
- Brought together organisations in the voluntary and 3rd sector to develop a cohesive offer for and front door for bereavement support
- Continuation of C(E)TRs
- Comprehensive wellbeing offers for staff

We have seen:

- Strong partnership across health and social care working to support vulnerable people with dementia and their carers.
- Excellent partnership working to devise and develop a workforce wellbeing offer

We now have:

- Consistent System wide representation on the MH Integrated Programme Board

Mental Health, Learning Disabilities and Autism continued

Workstreams

During 2020/21 we will focus on the following workstreams:

- MH Integrated Community Care (MHICC) – development and co-production of a new integrated primary and community mental health service offer
- CYP MH Transformation Programme – supporting the implementation of the THRIVE framework linking into wider system work on SEND and neurodevelopmental disorders as well as increasing capacity in local community eating disorders provision
- Serious Mental Illness Physical Health Checks – continued rollout of Phase 2 of the pilot integrated model of provision linking into the Primary Care Health Inequalities workstream
- Learning Disability Annual Health Checks – working with primary care colleagues as part of the inequalities workstream
- Suicide Prevention and Bereavement Support – partnership working to continue development of real time surveillance and a bereavement support offer
- Neurodevelopment Disorders including Autistic Spectrum Condition Diagnostic and Post Diagnostic Support Pathways – working jointly with Local Authority partners to co-produce new care pathways
- Dementia Services Review Implementation – mobilisation of new elements of the revised care model including procurement of dementia co-ordinators
- Care (Education) and Treatment Reviews/Dynamic Risk Registers – continuing to meet our statutory duty to facilitate C(E)TRs and further development of local dynamic risk registers
- Implementation of the MH Rehabilitation Review model of care – development of the new model of care which moves away from a bed based model of care to enhanced care in the community
- Supported Housing Model – joint work with local authorities to review and refresh the local model of supported housing as a key enabler of the new model of care for MH rehabilitation services
- Homelessness Health Offer – working jointly with local authorities and linking into primary care health inequalities workstream
- IAPT (Steps to Wellbeing) expansion – continue the development and expansion of provision of psychological therapies with an emphasis on integration with community physical LTHC provision
- Psychiatric Liaison – roll out of the Core 24 all age model across the three acute hospitals in Dorset to support interdependent UEC workstreams

In preparing for winter and any potential second surge, we recognise that the majority of workstreams are project based and unlikely to be impacted by winter pressures.

Operational teams are currently considering what additional community-based resource may need to be mobilised to mitigate the reduction in mental health beds. In the event of a second surge the MH Integrated Programme Board will review timeframes for current work priorities and adjust accordingly. This may include temporary suspension of project-based work.

Investments

All investments are detailed in table XX overleaf.

Trajectories to be added (see supporting templates)

Programme Governance

The mental health elements of this programme are over seen by the Mental Health Integrated Programme Board, which is jointly chaired by the CCG Head of Service and Service Director in Dorset HealthCare. The Senior Responsible Officer is the Director of Primary and Community Services in the CCG.

The Learning Disability and Autism workstreams fall under the governance of the Pan Dorset LD and Autism Programme Board chaired by BCP Corporate Director for Adult Social Care. The Senior responsible Officer for the programme of work is the Director of Primary and Community Services

Mental Health and Learning Disabilities Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
MH Integrated Community Care (MHICC)	Integrated model of primary and community mental health Consistent and high-quality care pathways and a network of services across primary care, voluntary sector and secondary sector and other agencies to better meet the identified needs and remove service gaps	Increased number of adults accessing the primary and community mental health service.	To be determined – NHSE transformation funding anticipated in 2021/22	Principle programme Lead	April 2021	
CYP MH Transformation Programme	Access to the right care at the right time in the right setting	Estimated 60-65% increase in CYP accessing support	Full investment requirement to be confirmed £1.2m FYE (2020/21) via MHIS	Principle programme Lead (CCG)	March 2023	
Serious Mental Illness Physical Health Checks	Reduction in Health Inequality – reduced mortality gap	60% of primary care SMI register receiving annual health check and related intervention	£186k FYE (2020/21) £tbc FYE (2021/22) Via MHIS	Programme Lead (CCG)	March 2022	
Suicide Prevention & Bereavement Support	10% reduction in suicide Zero suicide in MH In-patient settings		£153k (2020/21) NHSE Transformation Funding	Principle programme Lead (CCG)	March 2021	
Implementation of the MH Rehabilitation Review model of Care	Care Closer to Home Reduction in out of area hospital placements		£1.115m FYE (2020/21) MHIS	Head of Mental Health System Transformation (DHC)	March 2021	
Supported Housing Model	People with severe/enduring mental health needs can be supported in the community		n/a	Principle programme Lead (CCG)	September 2021	

Mental Health and Learning Disabilities Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
IAPT (Steps to Wellbeing) expansion	Improved access to psychological therapies. Achievement of national recovery rates.	Increase to 25% of prevalent population accessing treatment	£1.166m FYE (2020/21) MHIS	Head of Adult Psychological Services (Operations) (DHC)	March 2021	
Psychiatric Liaison – Core 24 all age model	1 hour response to ED mental health presentations		£977k FYE (2020/21) MHIS £1,073m – NHSE Transformation Funding	Senior Programme Lead (CCG)	March 2021	
Dementia Services Review Implementation – Dementia Co-ordinators	Increased diagnosis rates/reduced waiting times Improved offer of post diagnosis support		£100k (2020/21) Source to be confirmed	Head of Mental Health System Transformation (DHC)	March 2021	
Homelessness Health Offer via Homelessness Reduction Board			tbc	Principle programme Lead (CCG)	July 2021	
Neurodevelopment Disorders including Autistic Spectrum Condition Diagnostic and Post Diagnostic Support Pathways review	Reduction in diagnostic waiting times Improved post diagnostic and crisis support		n/a (2020/21)	Senior Programme Lead (CCG)	April 2021	
Care (Education) & Treatment Reviews / Dynamic Risk Registers	Reduction in specialist hospital admissions (LD/Autism) People are cared for in settings closer to home		Varies Individual Commissioning Care Packages – Sec 117 / named patient	Care & Treatment Review Co-ordinator	BAU	

Urgent and Emergency Care and Winter Room Programme

Progress made during Covid-19

- During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- designed, delivered and implemented surge and escalation plans between IUCS and the PCNs which were clinically led
- increased 111 capacity and capability during early Covid-19 response
- Implemented changes to UTC and MIU capacity and access arrangements

We have seen:

- working together, innovating at pace to find and implement solutions in an integrated way of working and reduce demand
- resilience, flexibility, skills and enthusiasm of our workforce to deliver the best care
- ability of the public to change the way they access services;
- digital solutions – sharing patient records to improve safety and continuity of care; to provide services; remotely e.g. telephone and video consultations; and to access timely clinical advice

We now have:

- EPS
- Bookable appointments to MIU/UTC (no walk in's) (Being reviewed)
- ED streaming/triage to UTC/MIU
- Technology enabled care e.g. video consultations

Workstreams

To manage demand for non-elective services our Integrated Urgent and Emergency Care and 999 transformation plans have been developed. During 2020/21 we will focus on the following workstreams:

- Clinically validating more Ambulance Category 3 & 4; and ED dispositions from 111.
- increase alternative in and out of hospital pathways for ambulance conveyances includes -see and treat models
- Agree and implement ED front door model
- Think 111 First
- ECIST Care Coordination Model
- High Intensity Users model
- Develop plans for Rotational Paramedic Model
- Review and consolidate community offer for IAGPS model (link to 111 First)

We are also undertaking an urgent demand and capacity modelling exercise to understand the impact of winter, second surge and potential flu outbreaks.

Urgent and Emergency Care and Winter Room Programme continued

In preparing for winter and any potential second surge, plans have been adjusted to take into account winter and any potential second surge as identified throughout this plan.

We are looking to create eight additional critical care beds in Dorset Acute Units and increase our pool of nursing and AHP staff with ICU skills and competencies (maintaining recommended staffing ratio's for level 2 and 3 beds). Recruitment campaign is currently underway to identify 50 additional nurses (see critical care section XX).

Detailed winter plans are under development by each provider, these will be finalised at end of September, local assurance process to be confirmed.

We are putting in place a 'Winter Room' bringing together Covid-19, system resilience, infection control, EPRR and flu, in line with our seasonal escalation and response plans.

As part of our seasonal escalation and response plan, triggers have been identified that could potentially increase the pressure on the system in Dorset. If the triggers are notable a system surge management plan is created, gathering intel from across the ICS and cascaded out to partners. The Emergency Preparedness, Resilience and Response (EPRR) team is involved with planning and creating the SBAR reports which identifies potential risks and considerations ahead of the weekend. Cascading the SBAR report and the on-call names in order to expediate processes in case of any escalations. Our plans set out our response for:

- Severe weather
- Mortuary capacity
- UK transition
- Voluntary sector

In line with the national requirements our system flu plan is being developed and was submitted to NHSE/I on 24 August, outlining:

- Leadership & Governance
- Engagement & Communication
- Access
- Delivery Models
- Business Intelligence
- Preparation for a mass vaccination programme
- Identified current risks
- Work in progress

Testing

We continue to develop our Covid-19 Testing Strategy, in response to the national strategy and Local Outbreak Management Plans. Representatives from the Dorset Testing Cell regularly attend regional and national testing meetings in order to keep up to date with developments in policy and new initiatives and the Dorset Covid-19 Health Protection Board. We have developed a Dorset community swabbing service to support antigen testing of patients who are unable to access hospital or Pillar 2 facilities. We have also developed an online booking system and automated results system for antibody testing to support Phase 2 of the roll out of serology testing, with Phase 1 completed. The Dorset system hopes to extend this system to encompass activity under the SIREN study and any further roll out of regular antigen and serology testing for key workers.

Personal Protective Equipment (PPE)

We currently have good supply of PPE within Dorset, which has previously been a limiting factor. We will continue to link with the NHS Supply chain which will potentially be in place until the end of March 2021 and this will secure PPE for the four foundation trusts in Dorset and SWAST.

Primary Care does not have access to NHS Supply chain. Their main route of supply is through purchasing with independent suppliers that have been supported through the national stock routes. Any spending by PCNs on PPE will be reclaimed via the CCG under Covid-19. Practices do have access to the eBay e-Commerce portal in which they can order emergency stocks.

A solution for the ongoing supply of PPE is being led by the National teams, but the CCG is working in partnership with local procurement services to develop localised solutions that will support in the longer term. Mutual aid across the system will continue to be facilitated though the H&SC Silver PPE Cell

Investments

All investments are detailed in table XX overleaf.

Programme Governance

This programme is over seen by the UEC Board – Chair, Chief Executive of Dorset County Hospital, Senior Responsible Officer/ UEC Programme Director. Responsibility of delivery is by the Integrated Urgent and Emergency Care Workstream group, chaired by Dr Karen Kirkham and coordinated by Head of UEC.

Integrated Urgent Care Programme – Schemes/Initiatives Summary- to be updated

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Clinically validating more Ambulance Category 3 & 4; and ED dispositions from 111	Patients access right care, first time. Improved patient experience and outcomes Release more SWASFT resource to enable response times to improve across all ARP categories	Proposed %age reduction in call volumes to 999 to be established Proposed %age reduction in referrals from 111 to 999 to be established	Investment required into additional clinical support within the CAS	NEED TO CHECK WITH DORSET IUEC WORK PROGRAMME?	Phase 1 December 2020	
Think 111 First	Patients access right care, first time. Improved patient experience and outcomes	Proposed %age reduction in call volumes to 999 to be established	?	NEED TO CHECK WITH DORSET IUEC WORK PROGRAMME?	Phase 1 December 2020	
Validate lower acuity calls from 999 to 111/IUCS (transfer of calls)	Patients access right care, first time. Increased hear and treat rates Improved patient experience and outcomes Release more SWASFT resource to enable response times to improve across all ARP categories	Proposed %age increase of validation from 999 to 111 to be established	Digital/IT set up required. ITK link from SWASFT to IUCS Provide - £24k Further IT set up then required within the CAS Investment required into additional clinical support within the CAS	NEED TO CHECK WITH DORSET IUEC WORK PROGRAMME?	Phase 1 – Kernow CCG pilot site Phase 3 (post March 2021) – SW Roll Out	
Clinical validation of lower acuity calls in the 999 Hub	The benefits of this scheme: - increased hear and treat rates, thereby reducing on scene requirement and releasing capacity lower acuity patients receive a consistent level of clinical validation with that they would receive from the NHS 111 service	Proposed %age increase in hear and treat to be established	Investment required into additional clinical support within the 999 hub	Will Lee - Head of Clinical Hubs (SWASFT)	Phase 1 December 2020	
Rotational Paramedic Model	Phase 1 relates to developing plans for SWASFT in relation to its ability to host and have an offering to systems in relation to a rotational paramedic role	None phase 1 relates to planning and not implementation.	?	SWASFT	Phase 1 Plans to be developed.	

Integrated Urgent and Emergency Care Programme - Schemes/ Initiatives Summary- to be updated

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Agree system walk-in strategy and review UTC and MIU capacity	TBC	TBC	TBC	TBC	July - September	
Develop High Intensity Users Model	TBC	TBC	TBC	TBC	July - September	
Agree ED Front Door model	TBC	TBC	TBC	TBC	July - September	
Establish alternative in and out of hospital pathways for ambulance conveyances	TBC	TBC	TBC	TBC	July - September	
Establish Th111nk First team to scope requirements/gaps and develop plan for delivery	TBC	TBC	TBC	TBC	July - September	
Review IUCS model and consolidate Community offer for IAGPS	TBC	TBC	TBC	TBC	July - September	
System Seasonal Planning with a specific focus on winter and Covid-19	TBC	TBC	TBC	TBC	July - September	
Emergency Department (RBCH)- Minors Appointments 111	TBC	TBC	TBC	TBC	TBC	
Emergency Department (RBCH)- UTC/Minors Integration.	TBC	TBC	TBC	TBC	TBC	
Emergency Department (RBCH)- Streamlining Triage and RATS processes	TBC	TBC	TBC	TBC	TBC	

Cancer Programme

In line with the requirements set out in the Phase 3 letter, Dorset Cancer Partnership has reviewed their priorities and work programmes. We are planning to achieve the cancer performance trajectories, these will be delivered through the plans identified in the following section which includes, risk stratification of colorectal patients through FIT testing, continued use of the independent sector and use of the escalation protocol for patients requiring time-critical surgery.

104-day waits are reducing due to increased use of the independent sector and gradual recovery of capacity in the trusts, and the number of patients on the patient tracking list is increasing, demonstrating that the numbers of FT referrals is increasing and more patients are being treated within the timescales required. The 62 day standard is currently not being met, work is underway to improve our position in line with our plan

Key areas of concern are:

- patients not presenting in primary care with symptoms, although referrals are increasing, this will continue to be an areas of focus
- increase in head and neck referrals causing additional pressure on diagnostics, current capacity is able to meet demand however this is an area of focus, plans are being developed to mitigate issues including the addition of air flow solutions to reduce turnaround times
- Radiologists – workforce pressure; currently working on an image sharing technology solution for the ICS and supporting development of radiology networks across the region

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Faecal Immunochemical Testing for prioritisation of colorectal cancer 2ww patients
- Insourcing of colonoscopy capacity to deal with the 2ww colorectal cancer backlog, enabling Poole and Dorset County Hospital to clear their 2ww backlog with Royal Bournemouth Hospital procuring a mobile unit to create additional capacity,
- Utilisation of IS capacity to ensure all priority 2 cancer surgery has continued.
- Publication of a new website called Cancer Matters Wessex, providing information on Covid-19 specific information for cancer patients, cancer services, keeping well, and including a Directory of Services providing information about a range of support services across Wessex.

We have sorted cont.:

- Development of a new, Covid-19 related patient information leaflet for patients with a suspected cancer referral. A link to the leaflet is on the GP 2ww referral form.

We have seen:

- Greater clinical representation due to ease of attending virtual meetings
- A move to virtual patient triage and virtual outpatient attendance
- Most follow up cancer patients moved to remote follow up
- Greater use of e-consult by patients to access their GP

We now have:

- System Covid-19 guidelines for the Dorset ICS for cancer tumour site specific pathways taking into account changes due to Covid-19; developed and agreed by the Site Specific Groups and approved by the Clinical Cell
- Cancer Cell that meets bi-weekly to plan and implement recovery and manage risks and issues
- Teams site with channels for each Site Specific Group to enable SSGs meetings to take place virtually with access to the meeting documents for all members
- System wide agreed coding of deferrals due to COVID-19 and weekly data showing activity and performance within each tumour site pathway including bottlenecks in diagnostics or treatment due to COVID-19 deferral. This enables the cancer cell to focus efforts on recovery, to identify risks and issues, to manage interdependencies and to escalate where required
- Dorset ICS prioritisation of surgical cases in line with national guidance, with agreed escalation levels where surgery cannot be carried out within the timescale required: level 1: surgery carried out within the trust; level 2: surgery carried out within any Dorset trust; level 3: surgery carried out within any Wessex trust through mutual aid or within the Wessex Surgical Hub. The Wessex Surgical Hub was implemented by the Wessex Cancer Alliance as part of cancer recovery
- Virtual MDT meetings ensuring patient care could continue and enabling greater clinical engagement and better use of time
- Rapid Diagnosis Service at Poole Hospital for three Poole Primary Care Networks with Wessex Cancer Alliance rolling out the service to all Wessex PCNs.

Cancer Programme

Workstreams

During 2020/21 we will focus on the following workstreams:

Independent Sector Activity:

- **c**ontracts have been extended until December with an expectation that the NHS will be able to continue to access 75% capacity
- Trusts developing plans to re-establish capacity within NHS hospitals to prepare for the end of the IS contract

Endoscopy (links to Elective Care):

- Insourcing of additional activity has taken place. This has enabled Poole and DCH to clear their 2ww backlog. RBH has also procured a mobile unit to create additional capacity, and will also be supported by Poole to clear their 2ww backlog if necessary. The Dorset Endoscopy Network is leading on the implementation of new air flow technology to reduce turnaround times. The waiting list at RBH is being prioritised using FIT testing to ensure those at highest risk of cancer are prioritised for investigation.
- FIT to risk assess the routine waiting list and upgrade patient with unexplained bleeding to a 2ww pathway is being planned at RBH.
- Support the Adopt and Adapt programme

Surgical Hub:

- As mentioned escalation protocol in place for patients requiring cancer surgery within timescales set out in national guidance. Final stage of escalation is to the Wessex Surgical Hub, this has not been required as yet as patients have been managed locally within timescales.

Early detection:

- Cancer screening programmes recommenced (link to the Primary and Community Care).
- Digital approach for raising awareness of signs and symptoms and media campaigns in place to be extended.
- Case finding patients at high risk of cancer through the GP lists is commencing in October.
- Early detection of cancer local enhanced service is beginning in October to enhance the Early Detection Network DES.

Faster diagnosis:

- Robotic automation to be implemented in high volume 2ww pathways freeing up time for admin staff, nurse and consultants.

Trajectories- to be added

Investments

Detailed in table XX overleaf.

Programme Governance

This programme is assured by the Dorset Cancer Partnership Steering Board, with a Senior Responsible Officer- Chief Executive of Universities Hospital Dorset and has a dedicated Programme Director. The Joint Clinical Leads are Mr Richard Sim and Dr Sarnia Ward

Cancer - Priority Schemes/Initiatives Summary (1 of 2)

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Early detection of cancer: • Lung cancer case finding Local Enhanced Service • Early detection local enhanced service • Public facing communications campaign to raise awareness of lung cancer symptoms	Reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels;	Return 2ww referrals to pre-COVID levels	£100k for lung case finding LES from NHS E COVID budget £100k for cancer early detection LES from NHS E COVID budget	Project Manager, DCP Deputy Head of Programmes, DCP	Sep 2020 contracts signed for both LES. Schemes complete March 31st 2020.	
Cancer Matters Wessex website – Phase 1 launch including information about COVID-19 for people affected by cancer, and a Directory of Services developed by the Macmillan Team within the DCP. Phase 2 launch including cancer pathway information for the public and patients	Reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels;	Return 2ww referrals to pre-COVID levels.	£8k in addition to the contract amount for additional work on the website structure.	Project Manager, DCP	Phase 1 launch complete July 2020. Phase 2 launch due Nov 2020.	

Cancer - Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver (add in confirmed investment)	Lead	Timeframes	Update
Rapid Access Diagnostic Service: Support delivery led by Wessex Cancer Alliance of Rapid Diagnosis Service (RDS) at Poole Hospital, for patients with non-specific symptoms that could be cancer, followed by roll out to rest of Dorset.	Ensuring that sufficient diagnostic capacity is in place in Covid-19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres	30 referrals into the RDS in 2020/21	Investment from Wessex Cancer Alliance into the Wessex RDS hub based at Southampton Hospital. No investment into Dorset trusts to pump prime the service. Many eligible patients will be in the system already having been referred to multiple services within the trusts so savings are expected in future.	Wessex Cancer Alliance led	March 31st 2021	
Patient risk stratified follow-up (breast, colorectal and prostate cancer)	Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service. Improved patient experience.	50%-70% of PIFU appointments not required	£8k for RBCH to link to Somerset Cancer Register; £13k for DCH to undertake integration work; £9k for RBCH to put legacy patients onto the system; DCH to put legacy patients onto the system – funding to be confirmed.	DCP Project Manager	31st March 2021	

Elective and Diagnostics Programme Overview- speak with sally b

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Digital approach using technology in support of patient care and ways of working

We have seen:

- Video consultations – rolled out the use of video consultations across three acute trusts and 24 specialties seeing 650 patients a week at the height of the pandemic and sustaining with approximately 500 a week currently

We now have:

- Self Help and self Care Videos- procured and rapidly implemented a self help and self care video library locally adopting more than 300 videos with 2000 hits to date.
- Advice and Guidance -grown the use of telephone and written advice and guidance with a growing number of speciality being delivered across the whole county by one of the three acute trusts

Workstreams

Detailed plans have been developed for the following areas:

- Adopt and adapt programme:
    - Transforming outpatients
    - Endoscopy
    - MRI/ CT- to be added
    - Theatres
- 52 week/ waiting list system priorities:
    - Audiology
    - Ophthalmology
    - Orthopaedics
    - ENT
    - oral surgery

In preparing for winter and any potential second surge, plans have been adjusted to take into account winter and any potential second surge as identified throughout this plan.

Trajectories- to be added

Investments

Further work to be undertaken to understand future funding requirements.

Programme Governance

This programme is over seen by the Elective Care Programme Board, with a Senior Responsible Officer and has a dedicated Programme Director

The following sections provide an overview of each of the workstream areas.

Transforming Outpatients Programme

The objective of the programme it to redesign and implement a sustainable delivery model of care for accessing specialist clinical advice, diagnosis, treatment and ongoing management which provides better outcomes and experience for patients and clinicians.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Enabled online consultations
- Developed Information and User Guides for Clinicians and Patients to support the use of online video consultation
- Extended Consultant Connect providing telephone advice and guidance

We have seen:

- Adoption of new technology and innovation at a rapid pace
- Teams working together across organisations to deliver services
- Organisations delivering services across Dorset, on behalf of other providers

We now have:

- A much improved Telephone A&G offer (over 10 new services / specialities) for Primary Care across Dorset and a considerable increase in activity
- Clinicians completing virtual reviews of patient's notes and images
- Online consultations being delivered as 'business as usual' with positive feedback from both patients and clinicians
- Services across Dorset delivering online group sessions to enable services to continue and patients to access the advice and treatment needed e.g. antenatal classes, pain management
- Over 250 patient information videos live and available, with positive engagement from services

Workstreams

During 2020/21 we will focus on the following workstreams:

- Optimising referrals
- Enabling remote consultations
- Ongoing management
- Digitalising the outpatient pathway/ process and pathway inefficacies

In preparing for winter and any potential second surge, the continued use of A&G (written and telephone) will support reducing those patients that do not need to visit an acute hospital (ED attendance, admission or referral) as it will support Primary & Community care to better manage patients in the community. This also enabling staff to work remotely, to continue to deliver services and working through patient / clinic lists.
Delivering a PIFU approach across some services / specialities will support winter pressures and help to manage demand should there be a second surge.

Trajectories- to be added

Investments

Detailed funding requirements can be seen in the table overleaf.

Programme Governance

This programme is over seen by the Elective Care Board, with a Senior Responsible Officer – CCG Chief System Integration Officer and has a dedicated Programme Director – Deputy Director – Integration, and Programme Manager.

Transforming Outpatients Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Written A&G	Primary Care can access A&G, in writing via eRS or telephone, from secondary care. Provides access to specialist advice in a convenient manner for clinicians Supports providing care close to home Reduces unnecessary hospital attendances (ED attendance, admissions and referrals) Improved patient experience – avoid travel to hospital and associated stress and inconvenience Between 1 Feb & 30 June 2020, over 420 referrals avoided and approx. 150 ED attendances avoided.	Between April 2020 and June 2020, there has been a 60% increase in A&G requests responded to. Review those services / specialities that are not providing A&G and identify these as an area for opportunity The ambition is to sustain these activity levels to support reduction in referrals, hospital attendances	No investment required	Programme Manager – Transforming Outpatients & System Support Team	30 November 2020	
Consultant Connect – Telephone A&G		To sustain a minimum of 400 calls per month until the end of March 2021 To achieve the following percentage split of call outcomes recorded: • Less than 30% Referral Made • More than 30% Referral Avoided • Less than 10% Admission made • More than 10% Admission Avoided	Dorset's contract with Consultant Connect expires May 2021. Funding within CCG Budget for 2020/21. Therefore, no additional investment required.	Programme Manager – Transforming Outpatients	31 March 2020	
Virtual Clinics	Supports Dorset's vision to offer patients a 'digital first' approach by 2024/25 (aligns to LTP)	To reduce the number of in person, face-to-face outpatient appointments/visits to hospital by a third by 2024/25	No investment required	Programme Manager, Transforming Outpatients	31 March 2021	
Telephone Consultations	Enables an effective clinical consultation in a convenient manner for patients Supports reduction in waiting times and improves access to services	To complete a minimum of 25,000 video consultations across three acute trusts by 31 March 2020	No investment required		31 March 2021	
Online Consultations	Improved patient experience - saves patients the travel and day-to-day inconvenience	To implement online group sessions across a minimum of three services/specialities; aiming to save a minimum of 1,500 appointments/ visits by 31 March 2021	Part of NHS E/I Attend Anywhere pilot – expires 31 March 2021.		31 March 2021	
Online Group Sessions	Improved morale as enables staff to work flexibly Reduces staff / departments travel cost		Investment/funding likely to be required.		31 March 2021	

Transforming Outpatients Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
HCI Videos	Provide patient information (education, self-care etc) in a digital format that is easily accessible Improved patient experience Empowers patients and supports management of their condition(s)	TBC	No investment required. 3-year contract with HCI Videos in place and funding secured	Graduate Project Manager, Transforming Outpatients	31 March 2021	
PIFU	Reduces demand on outpatient services, in particular f/up apts Supports providing the right care at the right time Improved patient experience – appointment when of value and benefit to them, rather than at designated timeframes Empowers patients and promotes / encourages self-care and management	Reduce by an average of 4,400 per month over the 8 month period	Review in line with A&A	Programme Manager, Transforming Outpatients	31 March 2021	
Electronic Patient Portal	Provides a digital method of accessing appointments and correspondence Improved staff morale as less reliance on administration and paper processes Reduce printing and postage costs across Dorset ICS providers	TBC	Approx. 1.4 million requested, across Dorset's three acute trusts, as part of NHSE/I Capital Bid	Programme Manager – Transforming Outpatients Will require significant input from acute trust teams e.g. administrative, managers, clinician and IT teams	31 March 2021, depending on investment	
Virtual Check-In	Provides a digital method of 'check-in' either via a self-check-in kiosk or mobile app	TBC				
Designated virtual consultation space / telepods	Provides a designated space for clinicians to use to conduct virtual consultations (e.g notes reviews, telephone and video) and completely admin if needed Maximises use of clinic / consultation space as ensures those consultations that need the clinic equipment and space are able to use this	TBC				
Automating the eRS referral process (using RPA)	Reduced reliance on administrative and paper process Supports ambition to become paper-free Improved staff morale – reducing turnover of administrative staff Reduction in printing costs Improves quality and safety as referrals manged electronically, rather than in hard-copy	TBC	Investment post December 2020 required £150k transformation funds secured – enabled purchase of RPA until December 2020.	Paul Wyman – RPA Architect working closely with acute trust teams e.g. administrative, managers, clinician and IT teams	December 2020	

Endoscopy Programme

The objective of the programme it to redesign and implement a sustainable delivery model for the Endoscopy service; diagnostic and therapeutic treatment and ongoing management which provides better outcomes and experience for patients and clinicians.

Progress made during Covid-19

During our response to Covid and following the recent Hackathoan the Endoscopy Network has expanded to act as T&F to deliver the Adopt and Adapt programmes.

We have sorted:

- All Trusts have separated lower and upper GI's
- Mobile unit is running from RBCH – decreasing backlog
- Established Leads for each 'Intervention'
- Continue to use insourcing over the weekends

We have seen:

- High level of sustained clinical engagement and commitment across the clinical and managerial teams
- Region have allocated circ. £3m for Endoscopy. Initial bid was for £15m but hopeful further funding options may provide greater long-term plan security

We now have:

- Prioritise required assets across the Trusts – immediate impact required to increase capacity

Workstreams

During 2020/21 we will focus on the following workstreams:

- Clinical standardization (triage process, FIT testing, CT colonography, trans-nasal, endoscopy, fast-track referrals)
- Ventilation and Infection Control – specifically in upper GI's. Scoping air exchange of mobile ventilation units (capital bid funding)
- Understanding our data – extracting real-time data will improve system wide planning
- System wide wait list and prospective scheduling tool-first step to understanding combined estate and workforce (possible Capital Bid option?)

In preparing for winter and any potential second surge, TBC.

Trajectories- to be added

Investments

Capital Bid – circs. £3m. Caveats – Capital spend

Programme Governance

This programme is over seen by the Elective Care Board, with a Senior Responsible Officer – CCG Chief System Integration Officer and has a dedicated Programme Director – Deputy Director – Integration, and Programme Manager.

Endoscopy Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Clinical standardization	• Implementation of standardized Colorectal Pathway across Dorset. • Lower GI operating at pre-covid productivity (points pre list) • Fit Testing used for lower GI referrals • Consider extending provision of trans nasal endoscopy. • Scoping exercise to review potential expanding of CTC • Scoping air exchange of mobile ventilation units (capital bid funding) • IPC Guidance being reviewed • Air scrubbers	Dorset Model – already in use and working at DCHFT – all trust to adopt DCH – 75%, RBCH – 70%, PFHFT – 60-75%, DCHFT – 0% Reduce demand for Endoscopy	Capital Bid	Programme Manager Clinical lead – Sally Parry and Stephen Bridger	30 October 2020	
Ventilation and Infection Control		Capacity to double Capacity reverts back to pre-covid	Capital Bid	Rowena Green	Jan 2021	
Understanding our data	• Development of an Endoscopy dashboard which provides up-to-date information with a daily feed. Dashboard used to run local improvement cycles and conduct 'after action reviews' to understand utilisation • Pan-Dorset – single system to understanding combined estate and workforce (possible Capital Bid option?) • Establish passporting arrangements to allow endoscopists to work across ICS • Release/return all trained endoscopy staff back to Endoscopy • Skills audit completed of endoscopy staff to ensure lists are allocated optimally	TBC	Capital Bid	Robin Armstrong	31 March 2021	
System wide wait list and prospective scheduling tool-first			Capital Bid		31 March 2021	
Workforce					31 March 2021	
			Investment/funding likely to be required.	Kaye Woodward	31 March 2021	

MRI/CT Programme- to be updated

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

We have seen:

We now have:

Workstreams

During 2020/21 we will focus on the following workstreams:

In preparing for winter and any potential second surge, TBC.

Trajectories- to be added

Investments- to be added

Programme Governance

To be updated.

MRI/ CT Priority Schemes/Initiatives Summary- to be updated

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update

Transforming Theatres Programme awaiting further updates

The objective of the programme it to redesign and implement a sustainable delivery model of care for utilisation of Theatres and ongoing management which provides better outcomes and experience for patients and clinicians.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Care review of waiting list
- Adopt and Adapt programme Manager
- Maximise existing staff through role augmentation

We have seen:

We now have:

Workstreams

During 2020/21 we will focus on the following workstreams:

- Demand Reduction and Management
- Maximise Existing Capacity
- Implement additional capacity

In preparing for winter and any potential second surge, TBC

Investments

Detailed funding requirements can be seen in the table overleaf.

Programme Governance

This programme is over seen by the Elective Care Board, with a Senior Responsible Officer – CCG Chief System Integration Officer and has a dedicated Programme Director – Deputy Director – Integration, and Programme Manager.

Theatres Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Demand Reduction and Management	**Reprioritisation of specialties and consolidation of capacity** Reprioritise certain procedures with risk stratification of specialities. Executed through Job planning and list allocation – predicated upon flexible working patterns and prioritise all patients by benefit/outcome for the as opposed to chronological or volumes of patients treated.	Validation could see reduction of 5% Optimise the whole patient need in the correct finical setting, which might not be theatres / surgery.	TBC	Programme Manager – Jane Slater Sophie Jordan	TBC	
Maximise Existing Capacity	**Develop Integrated approach to managing selected PTLs:** Implement a coordinated list rather than undergoing a creation of a single list. Both the case review and selected specialities executed with a triage system and multidisciplinary team. Merged waiting list for certain specialities across RBCH and Poole to ensure patients are seen in priority order. Review and maximise the current theatre capacity to include staffing levels Additional operating capacity schemes: extending hours, utilise alternative theatre sources and resources and employ insourcing capacity	To achieve 90% of last years activity for both overnight electives and outpatient procedures by October 2020 Reduce the number of patients waiting for treatment longer than 62 days on an urgent cancer pathway, or 31 days on a treatment pathway to pre pandemic levels with a plan for managing those waiting longer than 104 days.	TBC TBC TBC	Programme Manager – Jane Slater Sophie Jordan		
Implement Additional Capacity	**Digital Surgical Hubs:** review the digital platform to support peri-operative medicine, optimisation of patients pre surgery. **Recruitment to ATP** programme with accelerated route to scrub roles subject to support from HEE and RCN.	To achieve 90% of last years activity for both overnight electives and outpatient procedures by October 2020	No investment required	Programme Manager – Jane Slater Sophie Jordan	TBC	

Orthopaedics Programme

The system Orthopaedic restart group is initially focusing on a reduction in patients waiting over 52 weeks on the RTT pathway.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Virtual fracture clinic (DCH)
- Introduction of a consultant led service (DCH)
- Virtual elective clinics (RBH)

We have seen:

- Prioritisation of the waiting list using the clinical guidance to surgical prioritisation during the coronavirus pandemic which was published in April 2020 (system wide)
- Utilisation of independent sector capacity (system wide)

We now have:

- Undertaken an initial scoping meeting
- Set up a system wide Orthopaedic Restart group to move forward our priorities/workstreams

Workstreams

During 2020/21 we will focus on the following workstreams:

- Performance Overview – waiting list and activity
- System Waiting List
- MSK
- Outpatients
- Conservative pathways
- Internal Recovery Plans
- Workforce review
- Independent sector capacity

In preparing for winter and any potential second surge, plans have been adjusted to take into account winter and any potential second surge as identified throughout this plan. There will be a need to cancel elective operating if emergency demand dictates. As mitigation system wide capacity schemes have been submitted to the region including a revenue request to outsource Orthopaedic activity. As part of the surge plans across the system elective operating and outpatient clinics will cease.

Trajectories- to be added

Investments

As part of the recent capacity return the system has prioritised the following schemes; an increase in G&A bed stock to enable elective recovery, continued use of the independent sector capacity, modular laminar flow theatres, increase in outpatient capacity and outsourcing of orthopaedic activity.

Programme Governance

This programme will be over seen by the Elective Care Board, with a Senior Responsible Officer; Chief Operating Officer, DCH and has a dedicated Programme Director - **TBC**

Orthopaedics Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Performance Overview	System wide performance monitoring tools. Reduction in 52 week breaches, waiting list backlog and improved performance against the RTT standard. Monitoring of activity levels by activity type.	N/A	N/A	Adam Savin/ David Mills	02 September 2020	
Consider the options and benefits in the introduction of a System Waiting List	Benefit appraisal of a system waiting list	N/A	N/A	Carol O'Mahony/Jo Clothier	12 August 2020 – complete	
Review of the system pathway including MSK Triage	Standardisation of referral protocols to ensure patients optimised prior to referral. To be able to streamline the referrals to the most appropriate place with full choice offered to the patient.	Full choice offered, clear waiting times, managing patient expectations and ensuring full optimisation.	None	Carol O'Mahony/ Nick Savva/ Jo Clothier/Paul Pavlou	Next MSK meeting 09 September 2020, discussion required with Chair (Christian Verrinder) to request this as an agenda item.	
Review outpatient capacity and platforms available to deliver the required consultations	Maximise virtual outpatient activity. Introduction of PIFUs at a sub-speciality level.	Aim for phase 3 ambition, subject clinical review. PIFU should reduce FU, this would need to be quantified following pilot.	None	Carol O'Mahony/Jo Clothier	Compare existing proposals by 02 September 2020 and agree the timetable for sub-speciality review.	
Consider the options and benefits of introducing new conservative pathways	Conservative treatment option for a selection cohort of patients and pain management.	TBC – following waiting list review.	For discussion at next system meeting on 02 September 2020	Carol O'Mahony/Jo Clothier	Mid-September 2020	
Internal recovery plans to share learning across organisations	Provider specific plans in place and to be shared across providers	TBC – for discussion at next system meeting on 02 September 2020	Reconfiguration of estate for both outpatients and inpatients required along with an increase in workforce, costs associated to be confirmed.	Carol O'Mahony/Jo Clothier	Complete – plans shared 18 August 2020	
Undertake workforce reviews to establish any capacity gaps and potential for alternative roles and additional recruitment	Review job plans and undertake gap analysis	TBC – following job plan reviews	TBC – following job plan reviews	Nick Savva/Paul Pavlou	End of September 2020	
Review available independent sector capacity within Dorset, outside of area and potential for outsourcing	Increase through put of patients through ISPs	Potential for 400 patients to be transferred to New Hall (not confirmed yet) Weekly ISP usage reported as per phase 3 request.	No additional cost due to national contract, to be monitored ongoing	Carol O'Mahony/Jo Clothier	For Dorset ISP commenced for New Hall, October 2020	

Orthopaedics/Trauma - Priority Schemes/Initiatives Summary (RBH/PH specific)

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Fractured neck of femur (#NOF) transformation	Improved time to theatre for our #NOF patients meeting the NHFD recommendations for best practice Improved theatre utilisation Return to pre Covid-19 ward footprint and capacity.	Reduction in bed occupancy and LoS target 15% reduction	• Provision of radiology for all trauma lists removing pressure of other trauma prioritised over #NoF for availability of Xray. (FluoroScan £80k). • Ring fenced #NOF lists (Nil) • All day surgeon availability (revenue) • Dedicated #NOF ward • Sensuim remote monitoring £316,484 (plus VAT) revenue against £340,000/year cost saving. • Cons revenue BC	John West General manager Orthopaedics and General Surgery Kieran Gallagher Consultant orthopaedic surgeon	31 March 2021	
Admitted trauma	Improved patient experience, reduced LoS,	Reduction in bed occupancy and LoS target 15% reduction and admission avoidance.	• Cons revenue BC	John West Kieran Gallagher & Simon Richards	31 March 2021	
Cauda Equina	Clear clinical management of condition based on national best practice. Improved patient experience and outcomes	Rapid transfer of confirmed cauda equina and appropriate clinical management of non cauda equina patients (incidence 1 in 300000 of population)	Nil	John West, Mark Farrar & Robert Moverly	31 March 2021	
Soft tissue	Defined management pathways of soft tissue referrals to trauma orthopeadics	Improved patient outcomes through rapid assessment and treatment	Nil	John West Nikki Kelsall & Charline Roslee	31 March 2021	
VFC	Sustain numbers of patients being managed in virtual setting and mitigate rise in referrals	Maintain 60% of referrals being managed virtually	MG and VFC Revenue BC	John West Nikki Kelsall	31 March 2021	

Audiology Programme

The system Pan Dorset Audiology Recovery objectives are to:

- develop a consistent Pan Dorset model
- return services to required diagnostic standards which are 6 week RTA (Target 99%)
- return services to required local standards which are 18 week RTT (Target 92%)
- explore opportunities for a blended service model that utilises possible high street hearing service provision
- explore opportunities of new technologies
- ensure the appropriate audiology programme links with Ear, Nose and Throat workstreams

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- To be updated

We have seen:

- To be updated

We now have:

- To be updated

Workstreams

During 2020/21 we will focus on the following workstreams:

- establishing common pan Dorset access and referral arrangements, and triage and prioritisation approaches
- full pan Dorset completion and evaluation of 'self-fit' to maximise face to face potential to aid recovery
- consider the use of volunteers to support patients and aid recovery plans

Workstreams cont

- Scoping of cohorts/numbers/cost to be outsourced to aid recovery and inform longer term model
- access to/conversion of suitable rooms in the West to enable clinics to aid recovery/ longer term service provision
- obtain indicative trajectory from ENT of the likely phasing and impact of demand to audiology.
- pooling of waiting lists to address longest waits/clinical prioritise with flexible use of pan Dorset clinical and develop revised trajectories
- consider of the requirements of independencies such as ENT, Community Paediatricians, School Hearing Service and Newborn Hearing Screening Programme (NHSP)
- progress discussion and due diligence regarding the option of a transfer to one Pan Dorset provider

In preparing for winter and any potential second surge, the service may be suspended in line with national guidance, however based on learning from the early stages the following will continue to be provided where possible :

- sudden hearing loss
- oncology patients
- remote fitting of hearing aids
- review current technology for remote hearing aid support – apps etc
- continue to use self-help video's and information
- encourage patients prior to appointments or telephone consultations to complete hearing tests online

Trajectories- to be added

Investments

Investments are detailed in the table overleaf

Programme Governance

This programme will be overseen by the Elective Care Board, with a Senior Responsible Officer; Chief Operating Officer, Dorset HealthCare University NHS Foundation Trust, and has a dedicated Programme Director- job title to be inserted.

Audiology Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Establishing common pan Dorset access and referral arrangements and triage and prioritisation approaches.	Standard access for patients across the county. Clearer understanding of demand across the county.	Should reduce demand/activity subject to access criteria being approved. To be confirmed on application of criteria.	Support of a Band 5/6 project manager for 6 months.	Sam Leonard	Within the next 6-8 weeks.	
Full pan Dorset completion and evaluation of 'self-fit' to maximise face to face potential to aid recovery.	An agreed model for future 'self-fits' in Dorset using a process that meets the patient's clinical and individual requirements Same Clinical pathways being followed across Dorset. The investment in alternative technologies will support a long-term plan.	East Dorset has currently cleared nearly 1000 patients from their waiting lists by implementing a remote process during the last 4 months. Potential for further efficiencies and reduction in follow up appointments using new technologies of remotely programmable hearing aids.	Support of a Band 5/6 project manager for 6 months. Remotely programmable hearing aids cost: benefit implications will be required. Band 7/8a clinical leadership time to review and embed new technology.	Sam Leonard	Within the next 6-8 weeks.	
To consider the use of volunteers to support patients and aid recovery plans	A reduction on support required by Audiology services for remote fits.	01.04.2019-31.03.2020 10 volunteers made 841 patient visits and have approximately an additional regular 500 patients supported during the year. Total contacts1341 Cost implication – travel £5,600	Support of a Band 5/6 project manager for 6 months. Support from Human Resources in volunteer recruitment.	Sam Leonard	Within the next 6-8 weeks.	
Scoping of cohorts/ numbers and potential benefit/ impact on recovery of outsourcing specific elements to aid recovery and inform longer term model.	To have an agreed model for in house provision and outsourced support.	Reduction in demand and % patients that could be outsourced to be assessed	Support of a Band 5/6 project manager for 6 months.	Kate Halsey/ Helen Williams/ Sarah Burt	Within the next 6-8 weeks.	

Audiology Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Access to/conversion of suitable rooms in the West to enable clinics to commence.	A Dorset wide Audiology service has sufficient testing rooms which meet national Audiology requirements Standardised Medical Devices across Dorset.	Additional capacity for approximately 1300 patient contacts per annum for each new room (subject to staffing being available).	Support of a Band 5/6 project manager for 6 months. *Based on previous Paediatric sound proof conversion in 2016.* £84,000 (without supporting equipment) £93,000 (with supporting equipment) *Adult rooms will be smaller in size therefore cost should be less than quoted above*	Sam Leonard	Within the next 6 months.	
Pooling of waiting lists to address longest waits / clinical prioritise with flexible use of pan Dorset clinical and develop revised trajectories.	Joint clinical pathways to prioritise patients across Dorset. Equity of access through using a central triage across Dorset. Single point of access for referrers.	To be reviewed - % change in demand will depend on approval of same access criteria	Support of a Band 5/6 project manager for 6 months. Additional clinical staff/locums. Approximate cost of 3.0 WTE B6 agency locums would be £204k per annum. Support of Business and Performance Team	Sam Leonard	Within the next 6-8 weeks.	
To consider the requirements of interdependencies such as ENT, Community Paediatricians, School Hearing Service and NHSP	System wide approach to Audiology services and support.	Reduction of time wasted from inequalities across Dorset. Improvement in patient experience. To be reviewed and audited.	Project management support for 6 months.	Sam Leonard	Within 6 months.	

Audiology Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Transfer to one Pan Dorset provider.	One Specialist Audiology Service for Dorset with one management and performance structure. Improved delivery of support to other key areas e.g ENT and NHSP.	Dependant on change to access criteria. Potential for admin and management efficiencies.	Project management support for 6 months.	Sam Leonard	Within 6 months.	
Commissioning of a Dorset wide high street model for routine testing and hearing aids.	Increased proportion of patients to access testing within 6-week target. Current position (13th July) against 99% target: • DCH 6.3% (29/460) • DHC 15.2% (101/665) Patient choice of provider. Care closer to home – improved patient access. Single Dorset pathway	Will result in a change of activity between providers. Reduction in secondary care activity replaced with high street commissioned activity. Volume TBC	Further work is required to fully understand the likely volumes. In the meantime, DHC activity for 2019/20: • 4025 adult assessments • 2327 adult hearing reassessments • 3099 hearing aid fittings AQP model in W Hants for age 18+ W Hants population is c550K which is similar to population of East Dorset PCN referring to DHC. W Hants service: • 2019-20 cost was anticipated £2.7m (£228 per month). • Ave activity per month (in 2019) was 1383 (for hearing test or test and hearing aid fitting).	Senior Programme Lead	February 2021	
Commissioning of an ear wax removal service (for irrigation and micro suction)	Improving outcomes for patients Removal of barriers to accessing audiology testing and care. Improved patient experience. Redirection of secondary care services to priority ENT activity.	Increase in activity as all current is ad hoc. No commissioned activity but any current actual TBC DHC activity for 2019/20: 1225 appointments (431 new and 794 FU)	TBC Risk associated with this as not currently commissioned	Senior Programme Lead	31 March 2021	

Ears, Nose and Throat Programme

The system ENT group objective is to improve elective care standards, Cancer Waiting Times (CWT) in line with NHSI trajectories and annual/operational plans over the next 12 months.

The current capacity within Poole Hospital's ENT department does not meet the demand for the service with the medical and dental staff working across the system, directly affecting the service provision to the other trusts within the system.

Due to Covid-19 and the disruption to services in healthcare across the globe but specifically the NHS, the ENT team have had to work flexibly and conservatively manage the risk to both patients and staff whilst managing the most vulnerable and unwell patients in the community. Short-term (up to October 2020), mid-term and long-term plans to establish a clear structure to provide ENT services back to the hospital and wider system are being developed.

The current waiting list for Poole alone sits at 2544 with 250 patients waiting over 52 weeks.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Flexible working

We have seen:

- Consultants managing follow ups using telephone and virtual (attend anywhere) clinics

We now have:

- Microsoft teams for communication through the team, with instant Teams messages regarding rotas and notes

Workstreams

During 2020/21 we will focus on the following workstreams:

- **Waiting list** - No 52-week breaches by end of Quarter 3 of 2020/21 and evidence of a reduction in the waiting list across Dorset during 2020/21
- **Cancer waiting list** - Reduce CWT breaches in ENT by the end of Quarter 3 of 2020/21
- Ensuring the **capacity meets demand** across Dorset
- **Medical Staffing –** provide a safe and efficient staffing complement to the Dorset System

Trajectories- to be added

Investments

To support national guidance on nasal and/or laryngeal endoscopy it is required to replace our obsolete flexible laryngoscopes with modern video scopes meaning the image is displayed on a video screen rather that via a direct eye piece. This helps to protect the operator from any aerosol produced during the endoscopy. It also supports the digital storage of the procedure to help reduce repeat examination and potential further exposure. Circa £250K Requested through central COVID capital funding – Awaiting outcome

Programme Governance

This programme will be over seen by the Elective Care Board, with a Senior Responsible Officer; Chief Operating Officer, University Hospital Dorset, management team of the head and neck directorate with Project management support

ENT Priority Schemes / Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Merge system waiting lists	Waiting time equality across the system. Improved patient experience.	N/A	Potential reallocation of admin support to central provider to manage booking process – Suspected 1 from each provider.	General Manager Head & Neck	30 September 2020	
Takeover use of Wimborne hospital theatres for H&N	increase in system capacity and ability to see and treat patients within 18 weeks of GP/GDP referral. Improved patient experience.	Planned increase of circa 18 patients per week.	TBC	General Manager Head & Neck	31 March 2021/ Ongoing	

Oral Surgery/Maxillofacial Programme

As set out on page XX Oral/Maxillofacial (OMF) is one of our main challenges. The system ENT group objective is to improve elective care standards, cancer waiting times (CWT) in line with NHSI trajectories and annual/operational plans over the next 12 months.

The current capacity within Poole Hospital's OMF department does not meet the demand for the service with the medical and dental staff working across the system, directly affecting the service provision to the other trusts within the system.

The current Waiting list for Poole alone sits at 1380 with 310 patients waiting over 52 weeks

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Flexible working

We have seen:

- Consultants managing follow ups using telephone and virtual (attend anywhere) clinics

We now have:

- Microsoft teams for communication through the team, with instant Teams messages regarding rotas and notes

Workstreams

During 2020/21 we will focus on the following workstreams:

- **Waiting list** - No 52 week breaches by end of Quarter 3 of 2020/21 and evidence of a reduction in the waiting list across Dorset during 2020/21
- **Cancer waiting list** - Reduce CWT breaches in OMF by the end of Quarter 3 of 2020/21
- Ensuring the **capacity meets demand** across Dorset
- **Medical Staffing –** provide a safe and efficient staffing compliment to the Dorset System

In preparing for winter and any potential second surge, plans have been adjusted to take into account winter and any potential second surge as identified throughout this plan.

Trajectories- to be added

Investments

Not identified

Programme Governance

This programme will be over seen by the Elective Care Board, with a Senior Responsible Officer; Chief Operating Officer, University Hospital Dorset, management team of the head and neck directorate with Project management support

Oral Surgery/Maxillofacial Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Outsource system LA waiting list to local ISP's	Large increase in system capacity and ability to see and treat patients within 18 weeks of GP/GDP referral. Improved patient experience.	Planned increase of circa 50 patients treated per week.	Work to be delivered at tariff and currently on PBR contracted covered under the NHS E Top up.	General Manager Head & Neck	31 March 2021	
Merge system waiting lists	Waiting time equality across the system. Improved patient experience.	N/A	Potential reallocation of admin support to central provider to manage booking process – Suspected 1 from each provider.	General Manager Head & Neck	30 September 2020	
Takeover use of Wimborne hospital theatres for H&N	increase in system capacity and ability to see and treat patients within 18 weeks of GP/GDP referral. Improved patient experience.	Planned increase of circa 18 patients per week.	TBC	General Manager Head & Neck	31 March 2021/ Ongoing	

Ophthalmology Programme

As set out on page XX Oral/ Maxillofacial (OMF) is one of our main challenges. The system ophthalmology group objective is to support the development and delivery of a RTT 52 week wait system wide recovery plan for Dorset and to achieve a sustainable impact on the system waits for both admitted and non-admitted pathways.

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- Risk rating for all follow-up backlog has been completed, seeing a number of patients engaged in routine monitoring discharged out to community providers or back to Primary Care
- Transfer of Poole Hospital activity to single waiting list at RBCH removing inequity in waits and offering soonest appointment to those waiting.

Workstreams

During 2020/21 we will focus on the following workstreams:

- High volume Cataract OPD and Factory Theatres;
- Glaucoma virtual and shared eye care services (SECS);
- Technician led 'virtual' clinics;
- Paediatrics pathway;
- Shared Oculoplastics pathway;
- Corneal pathway;
- Eye Emergency;
- Laser;
- VR cover

Workstreams

During 2020/21 we will focus on the following workstreams:

- **Waiting list** - No 52-week breaches by end of Quarter 3 of 2020/21 & Evidence of a reduction in the waiting list across Dorset during 2020/21
- **Cancer waiting list** - Reduce CWT breaches in OMF by the end of Quarter 3 of 2020/21
- Ensuring the **capacity meets demand** across Dorset
- **Medical Staffing –** provide a safe and efficient staffing compliment to the Dorset System

In preparing for winter and any potential second surge, plans have been adjusted to take into account winter and any potential second surge as identified throughout this plan as follows:

- Royal Bournemouth Hospital Eye Ward (11 beds, 2 side rooms and a paediatric 3 bedded bay) are currently not in use as inpatient beds. This estate is currently being re-purposed to house our daycase patients, as daycase bay is being used for cataract clinic. This has been re-sited from Eye OPD to manage flow and distancing. If the ward is highlighted for escalation purposes we will see a displacement and dip in this activity. Winter pressures will have minimal/no impact on OPD plans.
- A second spike in Covid-19 will result in routine surgery and non-urgent OPD being paused.

Trajectories- to be added

Investments

Detailed investments required can be seen in the table overleaf.

Programme Governance

This programme will be over seen by the Elective Care Board, with a Senior Responsible Officer; Chief Operating Officer

Elective and Diagnostics Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
High Volume Cataract OPD and Theatres	Mixed economy of NHS and In Sourcing resources to urgently address 52 week waits and secure a sustainable reduction in waiting times to OPD and surgery for cataract patients	Additional capacity and reduction in waiting list/long waiters	Approximately £150,000.00 for Insourcing (OPD & Theatre). £20,000.00 for WLI NHS sessions		August/ September 2020	
Glaucoma SECS	Management of routine monitoring to community Optometry	Increase management and flow out of HES	A&C Band 4 0.5 WTE		September 2020	
Technician led clinics	Management of diagnostic imagery for medical review and decisions on management plan	Increase flow of patients on a non-medical led pathway	Technician Band 4 1.0 WTE		October 2020	
Paediatric Pathway	Delivery of system wide paediatric pathway	Management of long waiters and sustained reduction of waits	Review of system position		October 2020	
Shared Oculoplasctics Pathway	Delivery of system wide oculoplastic pathway	Management of long waiters and sustained reduction of waits	Review of system position and delivery of equitable pathways for OPD and theatre management			
Laser	Delivery of additional laser session to reduce waits and numbers	Reduce to <25 patients with a 3/52 wait.	Additional Laser sessions @ £600 WLI cost		August 2020	
Corneal Pathway	Transfer of corneal pathway from DCHFT to RBCH	Management of pathway within specialist team	Within current establishment		September 2020	

Covid-19 Treatment and Critical Care Capacity

Dorset has lower critical care capacity than other regions across the South West (SW), we have worked with the region to develop a SW bid as well as our local plans to ensure we have critical care capacity as we go into winter and to manage any potential Covid-19 surge.

Our plans will enable us to have 8 additional critical care beds in Dorset Acute Units and increase our pool of nursing and AHP staff with ICU skills and competencies (maintaining recommended staffing ratio's for level 2 and 3 beds).

Progress made during Covid-19

During our response to Covid we have seen many benefits, as set out in the below:

We have sorted:

- the establishment of a temporary transfer service in the South West (Severn sub-region)
- contribution to regional bid for revenue funding to address both short and long-term objectives of recovery

We have seen:

- rapid implementation of resilience/emergency plans occur through established critical care networks
- providers operate in unison being supportive with mutual aid where required
- investment would provide a value return outside of COVID surge by satisfying unmet need, meeting demand growth over the next decade, and addressing health inequalities

We now have:

- experience from the work of the Critical Care Cell demonstrating that cross organisational and sector working with strong clinical and local engagement can deliver results

Workstreams

During 2020/21 we will focus on the following workstreams

- winter pressures/second surge (implement additional bed capacity and staff recruitment if phase 1 of regional bid is realised, staff recruitment will be supported by Our Dorset Workforce Delivery Team and increase in beds by experience of surge planning, recruit and/or train to maintain establishment and provide a cohort of reserve ICU staff)
- levelling up (plan implementation of phase 2 in anticipation of further outcome of regional bid) which will see additional critical care beds in Dorset (allocation to be confirmed - awaiting outcome of SW CC bid)
- leadership (recruit clinical leadership to local network until April 2021, review in March 2021 with possible extension).
- our bid also includes development of the 24/7 critical care transfer service across Dorset – reduce cancelled operations due to lack of critical care capacity, better outcomes for patients. Enhancements to critical care rehab team

Infection and Protection Control (IPC)

Within Dorset we have Bi weekly meetings for the Dorset ICS IPC cell, and we gather assurance of the practices in place by our providers in Dorset against the ongoing application of PHE's infection prevention and control guidance and the actions set out for minimising nosocomial infections across all NHS settings. Where possible we develop a Dorset consensus and system approach to ensure we are working towards the same actions and applications. We are also sharing the learning between organisations locally and regionally where appropriate through the Bi weekly regional meetings .

In preparing for winter and any potential second surge, our plans consider innovative staffing models– for example the nurse assistant programme delivering care to two ICU patients by a pair of a nurse and nurse assistant working together currently being trialled in Plymouth. In addition, all units continue to train reserve ICU staff and developing plans for hybrid and rotational posts in order to maintain a larger pool of nursing and Allied Health Professionals with ICU skills and competencies and many of these staff will be keen to work in ICU permanently if posts are available.

Planning for a second surge has been assisted by the experience of London and the Nightingale Hospital that demonstrated that a RED surge scenario of 1:6 nurse to patient ratio was not achievable and 1:4 was more realistic.

Depending on level of surge pressures then there is a distinct possibility that elective (urgent, cancer and time-critical) surgery will need to be shifted to independent sector. Routine elective surgery may have to be paused or shifted to independent provider if capacity permits.

Trajectories- to be added

Investments

Awaiting outcome of SW Bid

Programme Governance

This programme is over seen by the Critical Care Cell, with a Senior Responsible Officer- tbc and has a dedicated Programme Director- tbc

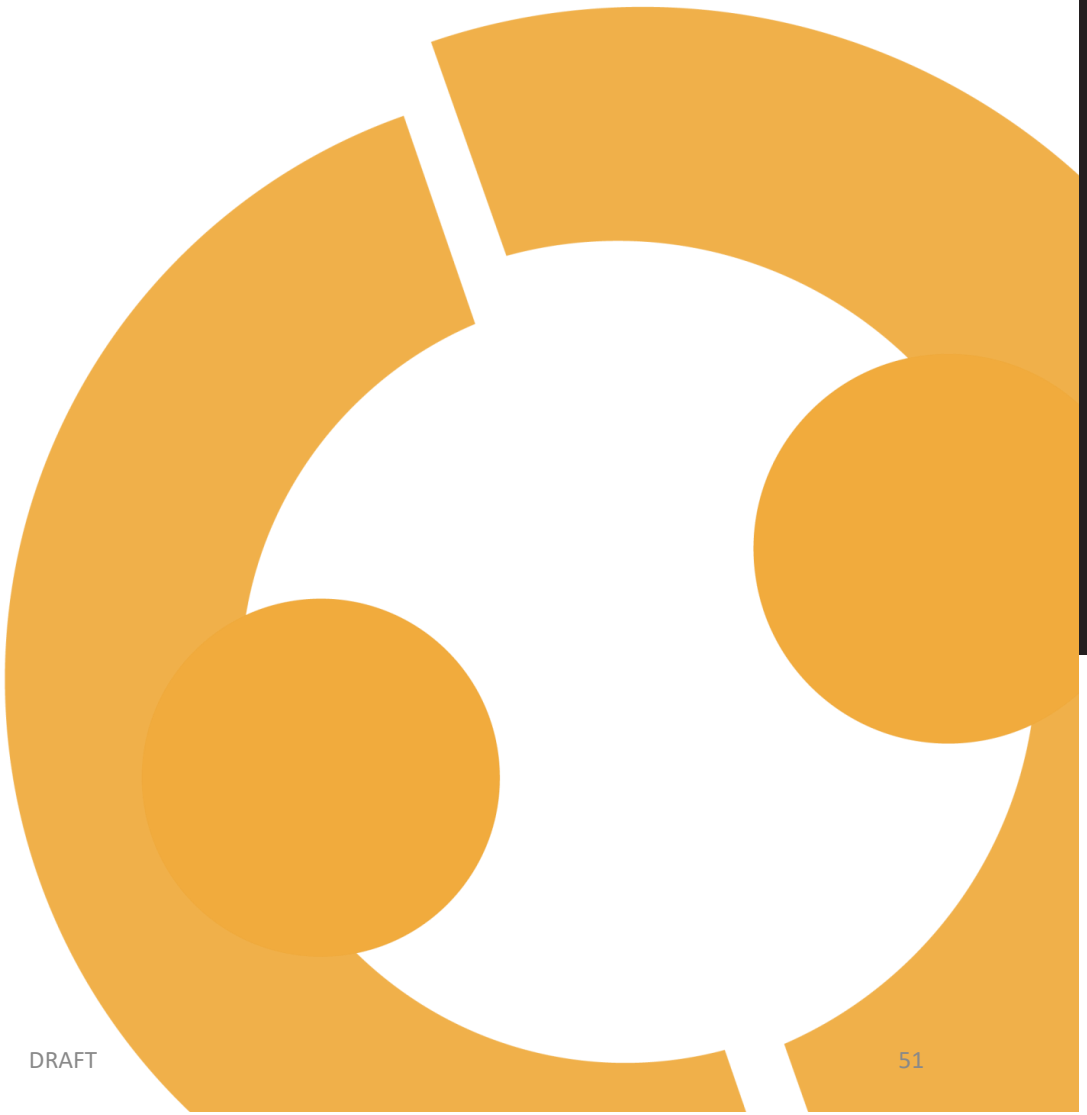
Covid-19/ Critical Care Priority Schemes / Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Recruit Clinical Lead	Clinical lead in post	Bot applicable however all other schemes will rely heavily on this role being appointed	Confirmed investment agreed until March 2021, then review	Sally Banister, Deputy Director – Integrated Care Development	Before end of August 2020	
Winter Pressures (phase 1)	8 additional critical care beds in Dorset acute units	Reduction in critical care transfers and cancelled operations, satisfies unmet need in sub-region	Unconfirmed outcome of SW regional revenue bid phase 1	Critical Care Clinical Lead - tbc	20 weeks from commencement 6 weeks campaign 12 weeks' notice 2 weeks contingency Likely that physical beds available sooner than staff to support them so may need to flex patient ratios depending on extent of pressures	
Winter Pressures (train reserve ICU staff and develop plans for hybrid and rotational posts)	Larger pool of nursing and AHP staff with ICU skills and competencies	Maintain recommended staffing rations for Level 2 and 3 beds	Funds may require allocating to backfill staff released for training from other parts of the system	Matrons, Finance colleagues in Trusts & CCG	Draft training programme available – comprises 8 x 4 hour modules for those new to ICU	
Phase 2 of Critical Care transformation	An extra 69 beds in SW region (sub-regional allocation to be determined but similar to phase 1)	Further reduction in transfers, fewer cancelled operations, ability to deal with Covid-19 2nd wave	Unconfirmed outcome of SW regional revenue & capital bids	Critical Care Clinical Lead with programme support - tbc	20-30 weeks from commencement to allow for estate reconfiguration, determination of how beds are allocated between Poole & Bournemouth could impact delivery	
Develop dedicated critical care transfer service	24/7 transfer service in place across Wessex and Dorset modelled on *Retrieve*	No ICU having to be degraded due to specialist staff having to accompany a transfer, significant reduction in cancelled operations due to lack of critical care capacity, better outcomes for patients	Unconfirmed outcome of SW regional revenue & capital bids	tbc	Estimated to take up to 18 months to design and fully implement	

Critical Care Priority Schemes/Initiatives Summary

Scheme/ initiative	Outcomes	Activity (% reduction/ increase)	Investment to deliver	Lead	Timeframes	Update
Enhancements to critical care rehabilitation	Meet core standards in FICM guidance for levels of staffing of AHP roles	Core standards delivered (roles are Dietician, Physio, OT, SaLT and Pharmacy)	Unconfirmed outcome of SW regional revenue & capital bids	Critical Care Clinical Lead, Matrons with support from Our Dorset Workforce Team	20-week minimum recruitment period (see earlier)	
Critical Care restoration Group (East of Dorset)	Provision of ICU capacity for Dorset for any future Covid-19 Surge	unknown.	NO additional highlighted capital, however workforce requirements would be required and this would be variable dependant if we go with option A or retain the current 8+1 unfunded ICU beds established at Poole Hospital NHS Foundation Trust	DCP Project Manager Richard Renaut		

Tackling Inequalities



Tackling Inequalities (1 of 2)

We are committed to ensuring that we establish our services to ensure equitable access and to minimise and further impact of health outcomes for the people of Dorset. In line with the eight urgent actions required to address inequalities we are undertaking the following actions across Dorset which have been identified within our earlier plans:

1. Protecting the most vulnerable:

- Covid-19 insights tool - being implemented within our primary care networks. This tool will be used to identify those at greatest risk to ensure they are supported appropriately; this includes identification and support to access preventative programmes and long term conditions management for those at most risk
- Shielding - working with the voluntary sector we will build on the progress we have made through our response to Covid-19, continuing to support those who are shielding when required
- undertaking work with Bournemouth University to gain a better understanding of the impact of Covid-19 across Dorset. The output of this work will inform both immediate recovery and future, including the areas for further engagement
- Communication - we continue to raise awareness of Covid-19 and prevention. We have campaigns in place to inform the public as to how best to access services including screening and prevention programmes including flu and winter

2. Restoring services inclusively:

- we are already risk stratifying patients to ensure those that are in greatest need are seen in a timely manner, in relation to their risk
- we will implement the new performance requirements to ensure that our restoration of services does not increase inequalities. We will work to understand the information we already hold and how this can be used to ensure our performance, taking appropriate action where inequitable access may be apparent

3. Digitally enabled pathways:

We will continue to build on the progress made during our response to Covid-19, enabling improved access to self-management apps, digital consultations across both primary and secondary care, advice and guidance etc. Our plans include continued implementation of:

- ***App library*** to support self-management
- ***Our Dorset Video library- Self care video***
- ***Healthier together website***, providing support and advice on managing children's health for families and consistent pathways of care for paediatrics across Dorset ICS
- ***Long term condition management*** digital approaches for COPD, diabetes, CVD and asthma, providing access to social prescribers, health coaches and clinical teams ensuring personalised care. In addition, we are remotely monitoring hypertension together with education and support to identified groups who are risk stratified through our Dorset Intelligence and Insight Service (DiiS).
- ***Pulse oximetry*** **-** Patients who are issued with a pulse oximeter will be remotely monitored by a clinical professional through a COVID-19, digitally enabled, virtual ward. Enabling earlier, more timely intervention, resulting in improved outcomes
- ***Enhanced care in care home*** – shared records and DSPT completed, remote access, embedding virtual consultations, training programmes to improve IT literacy, and device access
- ***Digital/ virtual outpatients***- continue to offer both telephone and video options for outpatients

4. Accelerating preventative programmes:

- Flu plan for Dorset ICS has been develop and includes communications campaigns. Strategic and delivery groups in place (add in plan on page?)
- Primary care screening programmes recommenced. Digital approach for raising awareness of signs and symptoms and media campaigns in place
- Covid-19 insight tool includes identification and risk stratification of populations to ensure those at greatest risk access preventative programmes and long-term conditions management
- Initiated work to restart LD Annual Health Checks recognising the increased risk posed to individuals with a learning disability
- We have recommenced the existing pilot for SMI physical health checks and begun work to recruit PCNs and required workforce for the 2nd phase of the pilot
- Occupational Health support and staff risk assessment for colleagues with protected characteristics identified through Covid-19 pandemic

Tackling Inequalities (2 of 2)

5. Support those who suffer mental ill health:

- We are reviewing and validating our mental health transformation and expansion plans. Several of our programmes have been delayed as a result of Covid-19 and the primary objective of recovery planning has focused on re-profiling timeframes for completion that aligns as closely to original requirements

6. Strengthen Leadership and Accountability:

- All partners have confirmed the leadership in place to take forward inequalities including primary care networks.
- Partners have plans in place to review and understand their workforce, including ethnicity and actions are to be developed.

7. Ensure data sets are complete and timely:

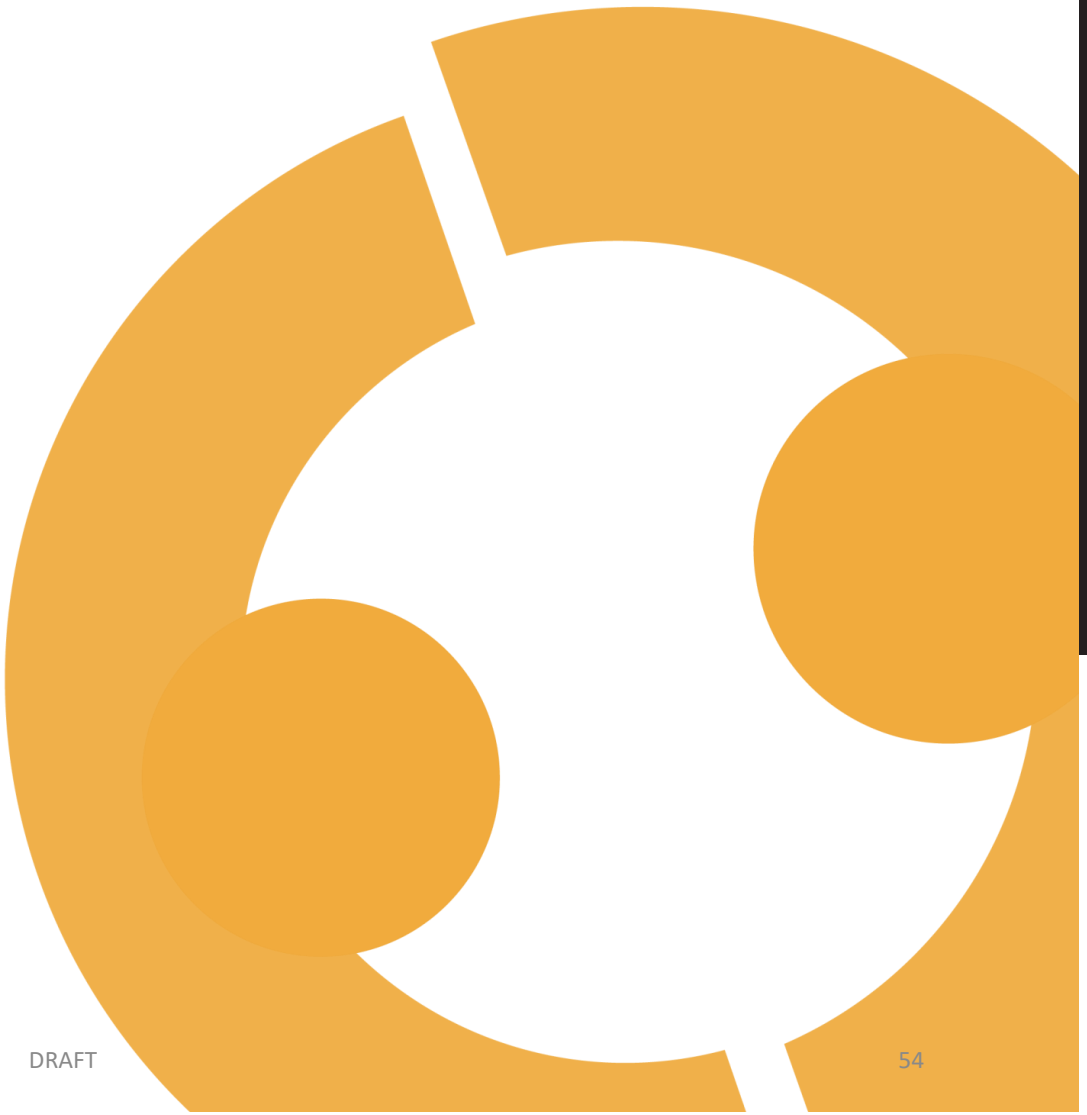
- Primary care - plans are in place to improve the ethnicity reporting in primary care by 1 September 2020, currently undertaking baseline assessment of records. Developed plans to capture all new registrants and those where this information is not already held.
- BI teams are reviewing ethnicity data and will establish gaps, action plan will then be developed to improve the position

8. Collaborate locally in planning and delivery

- System wide phase 3 recovery plan in development
- Performance and programme reporting to be reviewed and further developed to provide further information on how we are addressing inequalities locally
- We will develop plans to enable us to report by 31 March 2021 how we have used our resources to address inequalities and the outcomes we have seen

Any identified gaps and associated work programmes to be added

Workforce



Dorset People Plan and Staff Wellbeing

The Dorset People Plan has been co-designed in response to Dorset's Long-Term Plan ambitions and priorities and our pre-emptive planning for phase three recovery. The plan focuses on the short-term actions which we will take forward together, however it remains agile to reflect the evolving landscape and implications of Covid-19.

The national People Plan 2020/21 has reinforced our thinking and further informed our collective people priorities. Alongside the delivery of the Dorset People Plan we will review and refresh our People Strategy to reflect our Integrated Care System vision, purpose and priorities as well as the national People Plan ambitions and expectations.

Through our response to Covid-19 we progress several areas including:

- developing and implementing a mutual assistance framework to support the recruitment and redeployment of people and associated workforce related resources across health and care including returners and volunteers
- Our Dorset passport provided the mechanism to deploy staff across more than one setting of care and it is used locally across primary, community and acute care
- Attracting people to Dorset through digital campaigns, aimed at closing the nursing, pharmacy and allied health professional gaps, as well as more agile campaigns such as the recent phlebotomy campaign which was launched to support the expansion of antibody testing and attracted 28 expressions of interest in the first 72 hours
- NHS Heroes campaign which attracted 585 expressions of interest and of those 315 expressions were shared with trusts in line with their needs which resulted in 40 vacancies filled
- launched the nursing apprenticeship programme for people who are already working in primary care locally and to date we have received 11 applications; successful candidates will join the February 2021 cohort
- Dorset Primary Care Training Hub offer five co-designed flexible fellowship schemes and funding has been secured across our partnership to recruit 30 (medical, nursing and allied health professional) fellows in 2020/21 who will work within our Primary Care Networks and across our wider partnerships.

As part of our phase 3 recovery plan we will:

- expand the use of digital technology to augment clinical skills and enable workforce deployment including collaborative rostering, bank and job planning across our care system
- launch a campaign which celebrates the diversity of our workforce and promotes the wide range of opportunities we have in Dorset and our commitment to inclusion and equality
- respect, respond and promote mental and physical health and wellbeing of our staff through a number of interventions including flexible working opportunities and physical and psychological safety support
- equality, diversity and inclusion is at the heart of the work we do together and this means listening, understanding and responding to the diversity of our people's needs in such a way that people feel understood, valued and have a sense of belonging to our organisations. This is a golden thread throughout all our workforce programmes
- link with schools, colleges, parents and students is strong and we have adapted our approach to include virtual support and live interviews and podcasts

Our People Plan respects what is best done at an organisational level, system level and regional level. Our operating model promotes and encourages engagement and ownership, with distributed leadership through executive sponsors and dedicated system wide resources. We have developed a draft maturity matrix and alongside this we will monitor local metrics, drawn from the Dorset Workforce Data Warehouse which will go live from the autumn.

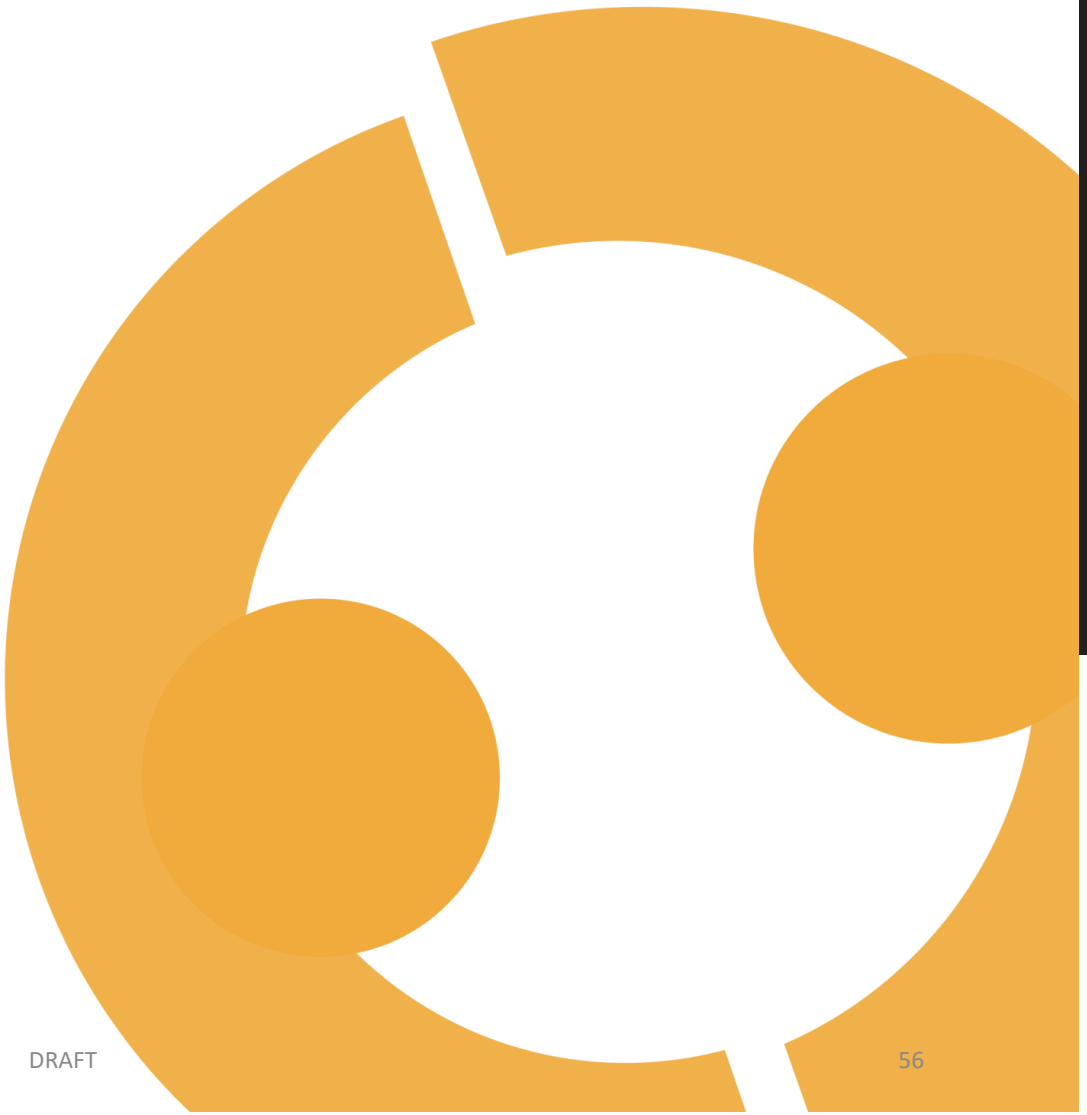
Investments

ICS investment in workforce operating model and expansion pipelines i.e Registered Nurse Degree apprenticeship

Programme Governance

This programme is over seen by the Dorset Peoples Board (Dorset Workforce Action Board), with a Senior Responsible Officer- Chair Dorset CCG and has a dedicated Programme Director.

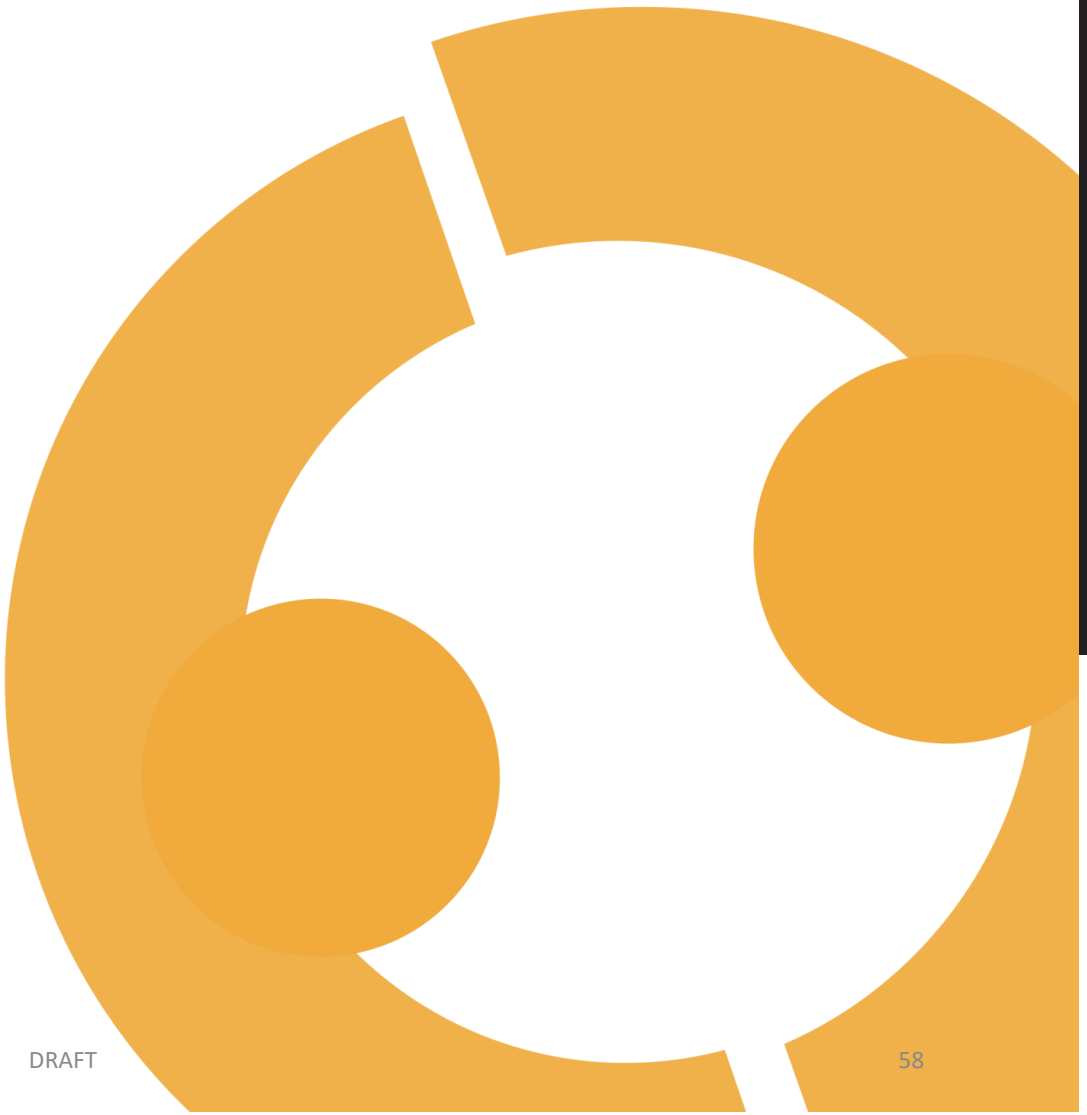
Finance



Financial Plan

To be added.

Communications and Engagement



Communications and Engagement

Since the start of the COVID-19 pandemic we have been proactive in our communications, working collaboratively on campaigns and messages to inform the public. System partners have worked in line with national Covid-19 engagement guidance produced by NHS England and Improvement (E&I) in March 2020. Significant efforts have been made to maintain, and strengthen, stakeholder relationships, keeping people informed and involved. Our response to COVID-19 included the following:

Communications:

- The launch of a #hereforyou campaign to communicate that services were still here for people to access during the pandemic
- An integrated recovery campaign #withyoudorset to communicate with the public about how services have changed, and to ask for their support in accessing services wisely, and looking after their own health and wellbeing www.withyoudorset.nhs.uk
- Ensuring that our communications are accessible to seldom asked/minority communities, e.g. co-production of traveler community video
- Using non-digital as well as innovative digital channels to communicate with seldom asked groups e.g. Instagram for young people
- Working in collaboration and partnership with system partners on joined up campaigns and communications, linking with the Warning & Informing Group.

Engagement:

- The regularity of meetings with groups like Healthwatch Dorset, Dorset Race Equality Council and the Community and Voluntary Sector organisations were increased – enabling a continuous conversation, informing communications. A weekly COVID-19 e-bulletin was circulated across all partner engagement and communication networks.
- In April 2020 existing engagement work was reviewed for impact on clinical activity, workforce, timescales and ability of local people to take part. It was then continued or postponed.
- Approaches are mindful of the need to consider inequalities and provide both digital and non-digital engagement options.

In support of Phase 3 we are:

Communications: Communications support is being provided to Phase 3 priority projects including 111 First (a communications task and finish group has been established to support this programme). A detailed communications and engagement plan will be created for this project. We are developing and adapting our recovery campaign in response to feedback from Healthwatch Dorset and the NHSE&I South West Region COVID-19 Insight survey to further develop, inform and improve our communications.

We are implementing a series of campaigns with partners, including a flu vaccination campaign, a Dorset-wide winter preparedness campaign, workforce campaigns. We are also working with partners/community groups to ensure that our communications reach the seldom-asked/minority groups through co-production and collaboration.

Engagement: Engagement leads from across all health, care, voluntary sector and partner organisations met weekly and now fortnightly. Public engagement is being reviewed continuously, in line with statutory duties to involve.

All Dorset's stage-3 COVID-19 recovery priorities have been reviewed in terms of engagement and communications, in line with NHS E&I guidance "Good practice for stakeholder engagement on service change and reconfiguration during COVID-19" produced in August 2020.

Dorset engagement leaders informed the development of a NHSE&I South West Region COVID-19 Insight survey. 1,747 Dorset residents responded to the survey. Regional SWOT analysis is currently being carried out and Dorset has commissioned additional analysis linked to Dorset's Phase-3 COVID-19 recovery priorities. The outcomes will inform this recovery plan. Longer term Bournemouth University has been commissioned to review and analyse 22 pieces of COVID-19 insight work collected locally and regionally. The outcomes will future planning.

It is important that our engagement work is flexible and iterative as recovery progresses and to be mindful that there are still many unknowns such as time-frame, and potential further peaks which will affect engagement. In Sept 2020 the ICS engagement leads are co-designing a set of engagement principles around working in partnership with people and communities. These principles will reflect local learning from the Covid-19 insight work and the recent "Five principles for the next phase of the Covid-19 response" produced by National Voices.

Governance and Assurance

Dorset ICS Governance and Assurance- DRAFT

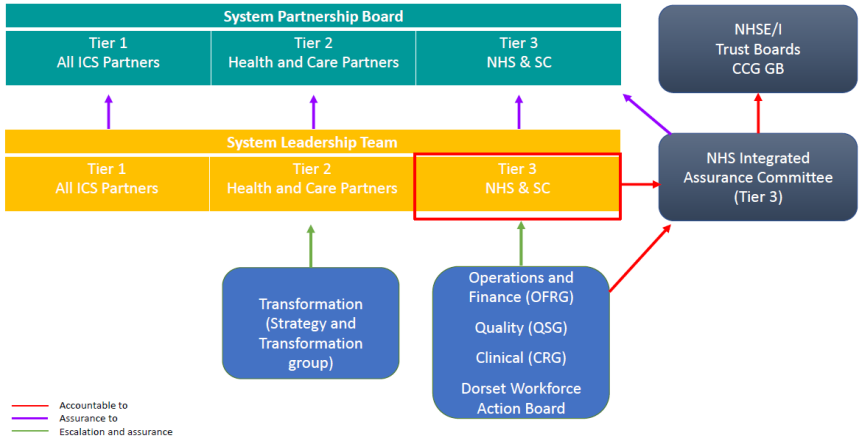
As part of our ongoing ICS development, we have reviewed our governance and assurance process.

The proposed draft governance arrangements has been informed by several factors as follows:

- the ICS currently has no formal delegated decision-making authority - it is a collaboration of partners, therefore recognising that decisions can only be made where statutory organisations have developed certain powers to the officers attending or any decisions in line with an existing decision the statutory organisation has already taken
- formal oversight and assurance requirements set out by NHS England/ Improvement relate to NHS partners only

As illustrated below the proposed governance has been based around the three levels of priorities, with the introduction of a NHSE Integrated Assurance Committee. Assurance will be provided up to SLT through the relevant subgroups (OFRG, QSG, CRG, Peoples Board, Strategy and Transformation).

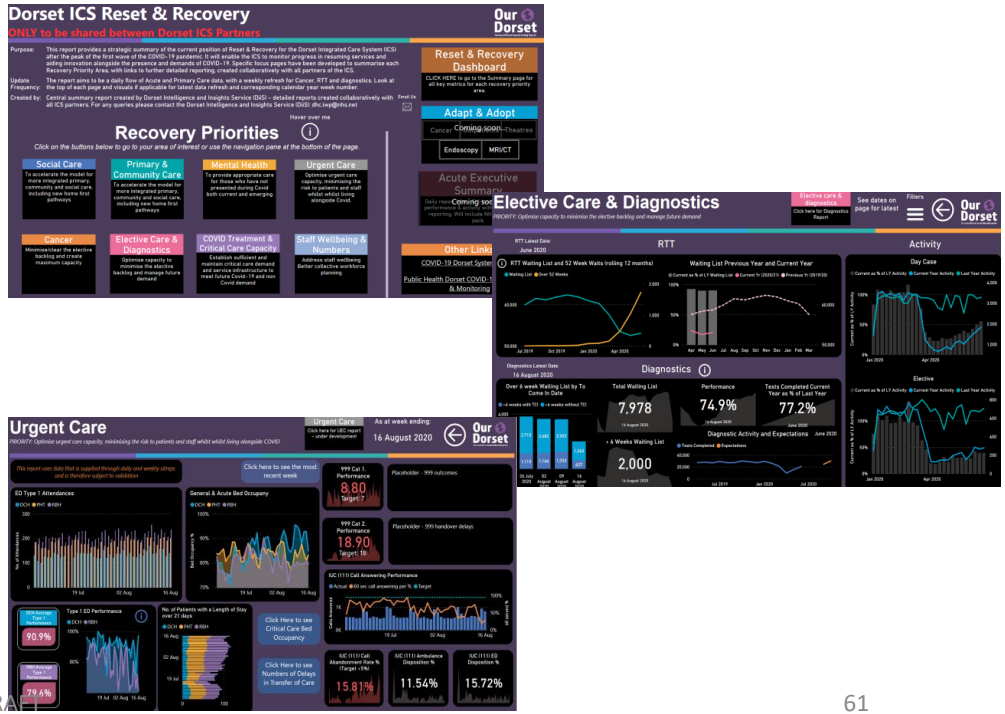
The proposed governance will be presented to SPB in October for formal agreement.



To enable the system to be assured recovery is on track in line with our local and national trajectories, a reset and recovery dashboard has been developed.

The dashboard **Dorset ICS Reset and Recovery** contains:

- a link to the ICS priorities as set out by Health and Care Recovery Group
- pages to support all Reset and recovery ICS priorities
- links to additional detailed reports to underpin these high-level metrics
- NHSEI Adapt and Adopt tools as they become available

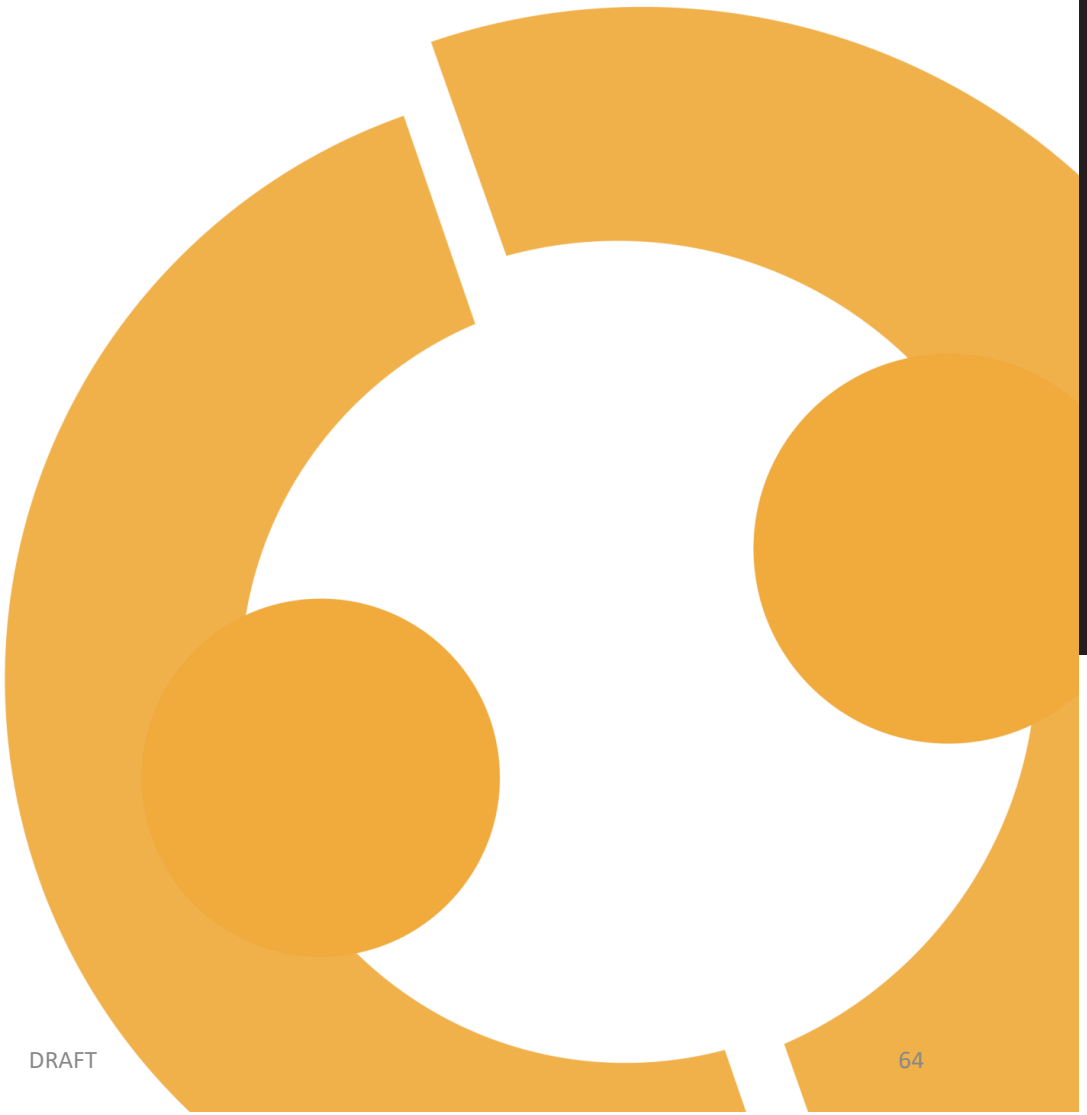


Risk and Mitigating Actions

Risk and Mitigating Actions- to be added

Risk	Severity	Likelihood	Mitigating Action

Appendices- supporting plans/ links to be added



Dorset County Hospital
NHS Foundation Trust

Health Inequalities – Action Plan

Version 1 – September 9th

Ref	P3 Action Ref	Key Requirement	Lead	Applicable and DCH actions to deliver	Progress
01	C2/005 C2/006	Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place by 15 September in every NHS organisation, alongside action to increase the diversity of senior leaders.	Catherine Youers Emma Hallett	-Board to confirm Exec Lead in September - DCH People Plan and OD/D&I Lead to develop action plan to increase diversity of senior leaders - Paper to Workforce Committee	
02	C2/007	Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.	Adam Savin and James Woodland	-Measure baseline of main activity types by end of Sept -Identified actions to increase coverage by end of October - Primary Care prioritisation – CCG applicable	
03	C2/001	Protect the most vulnerable from COVID-19, reflected in regular updates to system plans, with enhanced analysis and community insight, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; Better engage those communities which need most support.	James Woodland	-Phase 3 ICS and DCH Ops Plan -DIIS insights for primary care networks etc including socio-economic data https://app.powerbi.com/view?r=eyJrIjoiNGE1MGNjMDYtYjg4Yy00MTM2LWFhNmEtMmQwM2VmZjIxOWVhIiwidCI6IjFmNGE1NTIyLTVmNWEtNDk3NC04ZDk1LTlhMDMyZjRjZjJlNSJ9 -Included within Population Health Management approach -DCH Social Value Programme -Expand PALS and other link ups with community groups	
04	C2/002	Restore NHS services inclusively, so that they are used by those in greatest need.	Adam Savin and James Woodland	-DCH Operational Recovery Plans and clinical prioritisation to build in HI consideration	

		This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.		-Establish measurement of service use by end of September	
05	C2/003	Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.	Catherine Abery-Williams, Ruth Gardiner, James Woodland	-Focus required on on 4 pathways first - 111 First, Triage GP, MH, VOP - Virtual Outpatients T&F Group and Digital Portfolio Board to ensure HI/inclusion built in to new digital pathways - Primary care referral point – is the patient able/suitable for virtual - Systems able to capture and report on usage	
06	C2/004	Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers by 31 March.	Christian Verrinder	-ICS Plans and PH approach to prevention. Prevention at Scale Programme -Flu vaccinations programme at DCH https://app.powerbi.com/view?r=eyJrIjoiMjYwZTY1YjctMGMyNy00NjMyLWIwMjUtZjM4MWYyOWU2MmUxIiwidCI6IjFmNGE1NTIyLTVmNWEtNDk3NC04ZDk1LTlhMDMyZjRjZjJlNSJ9 -Populations Health Management Programme e.g. DCH Locality links COPD. -Maternity carers programme -LD – PC.	

Ref	P3 Action Ref	Key Requirement	Managerial Lead	Applicable and DCH Actions	Progress
07	N/A	Particularly support those who suffer mental ill health as society and the NHS recover from COVID, underpinned by more robust data collection and monitoring by 31 December.	James Woodland	-DHC led on MH -DCH – monitoring and sharing of information where appropriate -System – link up secondary care and primary care data to identify patterns between MH and physical service access e.g. RIO data and 111 contact overlay?	
08	C2/004	Collaborate locally in planning and delivering action to address health inequalities, including updating immediate plans for restoring critical services by 15 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.		-Identified as ICS priority -ICS Recovery Plan -Social Value/Anchor Institution agenda as an ICS priority -PCN engagement/place-based care	