Agenda

Council of Governors
2.00pm – 4.00pm, Monday 9 November 2020
Via Lifesize Video Conferencing

Part One Agenda – Open Meeting

1.	**Welcome and Apologies for Absence:**		2.00-2.10	Chair
2.	**Declarations of Interest**			All
3.	**Minutes of Council of Governors Part One Meeting 7 September 2020** To approve	Enclosure		Chair
4.	**Matters Arising from those Minutes and Actions List** To receive	Enclosure		Chair
5.	**Lead Governor Appointment** To approve	Enclosure	2.10-2.15	Trevor Hughes, Head of Corporate Governance
6.	**Chief Executive's Report Q2** To receive	Enclosure	2.15-2.30	Nick Johnson, Director of Strategy, Transformation and Partnerships
7.	**Finance Report Q2** To receive	Enclosure	2.30-2.45	Paul Goddard, Chief Financial Officer
8.	**Mortality Reporting/Learning from Deaths** To receive	Enclosure	2.45-3.00	Alastair Hutchison, Chief Medical Officer
9.	**2020/21 Priorities** To receive	Enclosure	3.00-3.15	Nick Johnson, Director of Strategy, Transformation and Partnerships
10.	**NED Update and Feedback**	Verbal	3.15-3.30	Judy Gillow**,** Vice Chair, Chair of Quality Committee, Interim Chair of Workforce Committee

11.	**Governor Matters:** a) COVID Update To receive	Verbal	3.30-3.50	Inese Robotham, Chief Operating Officer
12.	**Governance Items**		3.50-4.00	Trevor Hughes, Head of Corporate Governance
	a) Vacant Seats To approve	Enclosure		
	b) **Governor Committees Re-Start Plans** To discuss	Verbal		

13. Date of next meeting:

A Part Two (confidential) meeting of the Council of Governors will be held on Monday 16 November 2020 at 10.30am via Lifesize.

Date of Next Meeting (open to the public): Council of Governors TBC February 2021 via Lifesize

Meeting Closes 4.00

Council of Governors Meeting: Part One

Minutes of the Meeting of Monday 7 September 2020
via Lifesize Video Conferencing

Present:	Mark Addison (Chair)
	Public Governors Margaret Alsop (Weymouth and Portland) Simon Bishop (East Dorset) Stephen Mason (Weymouth and Portland) Gavin Maxwell (West Dorset) Christine McGee (North Dorset) Naomi Patterson (West Dorset) Maurice Perks (North Dorset) Sharon Waight (Weymouth and Portland)
	Staff Governors Tracy Glen Tony James
	Appointed Governors Tony Alford (Dorset Council) Peter Wood (Age UK)
In Attendance:	Rees Batley (KPMG) (to item CoG20/055) Liz Beardsall (Deputy Trust Secretary) (minutes) Paul Goddard (Director of Finance and Resources) (item CoG20/056) Trevor Hughes (Head of Corporate Governance) Ian Metcalfe (Non-Executive Director) Patricia Miller (Chief Executive (item CoG20/049) Ben Print (Programme Manager) (item CoG20/058) Natalie Violet (Corporate Business Manager) (item CoG20/049)
Apologies:	Sarah Carney (West Dorset) David Cove (West Dorset) (Lead Governor) Davina Smith (Weldmar Hospicecare) David Tett (West Dorset)

CoG20/049 **Chief Executive's Report: Q1 Report 2020/21**

The Chair briefly welcomed everyone to the meeting and explained that for scheduling reasons, the meeting would take the report from the Chief Executive and then return to the formalities.

The Chief Executive referred Governors to the previously circulated report which provided a summary of the first quarter of 2020/21 and challenges that the hospital now faced during the next phase of the NHS response to COVID-19 (Phase 3). In response to questions from the Governors, she explained that cancer services had

continued across the NHS during the pandemic and it was a misrepresentation by the media to say that this had not been the case; that she could provide information to the Governors on the methodologies that underpinned the national performance metrics but that these were in parts very complex; that all the Trust's orthopaedic work was currently being undertaken at the BMI The Winterbourne Hospital as part of the national sub-contracting of care into the independent sector and that there were concerns on a national level regarding the cost of the recovery of orthopaedic waiting lists.

ACTION: PM

The Chair thanked the Chief Executive for her report, and the Chief Executive thanked the Governors and left the meeting.

CoG20/050 **Welcome and Apologies for Absence**
The Chair welcomed everyone present to the meeting. There were apologies from Sarah Carney, David Cove, Davina Smith and David Tett.

CoG20/051 **Declarations of Interest**
The Chair reminded Governors that they were free to raise declarations of interest at any point in the meeting should it be required.

CoG20/052 **Minutes of the Previous Meeting held on 3 February 2020**
The minutes of the previous meeting held on 3 February 2020 were accepted as a true and accurate record.

CoG20/053 **Actions and Matters Arising**
It was noted that the Dorset Care Record presentation slides had been circulated and amended (CoG20/008) and that it was proposed that all other actions from the February meeting be closed at this point, they had been as superseded by the pandemic. The Chair said Governors could request to reopen these actions should they come up in the course of future Governor business.

It was noted that no items for the Governor Matters agenda item had been received prior to the meeting.

CoG20/054 **Interim Lead Governor Arrangements**
The Head of Corporate Governance referred Governors to the previously circulated report outlining two proposals relating to the Lead Governor role following the pause to the Governor elections earlier in the year. He explained that the proposals were to extend David Cove's term as Lead Governor to 9 November if Dr Cove was re-elected in the Governor elections or for the Chair to appoint an interim Lead Governor from 1 October to 9 November if Dr Cove was unsuccessful. The Chair confirmed that he had discussed these proposals with Dr Cove, who was content with the recommendations, and that following the end of the Governor elections the selection process for a Lead Governor would proceed in the usual way.

Resolved: the Council of Governors unanimously agreed to the proposals regarding the interim Lead Governor arrangements.

CoG20/055 **External Auditor's Statement on the Annual Report and Accounts 2019/20**

As the meeting was running ahead of schedule and Rees Batley from KPMG was in attendance, the Chair suggested that the external auditor's item be moved up the agenda.

Rees introduced himself to the meeting and explained that this was the second year that KPMG had been the Trust's external auditor and prior to this they had provided the internal audit function. He explained that due to COVID pandemic, this year's audit of the Annual Report and Accounts had been conducted entirely remotely but that, despite the challenges this presented, the audit had been completed on time. He said that the audit raised no significant issues and this was a testament to the Trust's finance team, their relationship with KPMG and the relationship with the Risk and Audit Committee. Rees explained KPMG's key responsibilities in relation to the financial statements, the quality report, use of resources and whole Government accounts. In relation to the financial statements he reported no significant issues with only two low-priority control observations made. He reported that a clean opinion had been given in terms of the Trust's use of resources. He outlined KMPG's future work plans with the Trust including the possible challenges relating to COVID and the arrangements relating to the Trust's capital investment funding. In response to a question from the Chair, Rees said he thought the biggest challenge for the hospital would be the capacity of the senior management team to deliver the COVID restart and recover work in addition to their usual roles, given the relatively small size of both the hospital and the senior management team.

The Chair reminded Governors that the Annual Report and Accounts was available on the Trust's website and would be present at the AGM later in the year. He thanked Rees, the team at KPMG and the finance team at the hospital for their joint working in challenging times.

The meeting took a short break.

CoG20/056 **Finance Report: 2019/20 Summary and Q1 Report 2020/21**

The meeting reconvened and the Chair welcomed Paul Goddard, Director of Finance and Resources.

The Director of Finance presented the previously circulated report which provided a summary of the Trust's financial position at the end of the 2019/20 financial year. He reported that the Trust delivered an income and expenditure surplus of £200,000 for the 12 months ending 31 March 2020 against a planned break-even position. He explained that this position had been reached due to additional funding of £2.5 million from Dorset Clinical Commissioning Group. He drew Governors' attention to the increased pension contributions (paragraph 1.2) but explained that the increased cost had been covered by funding from NHS England. He also provided details in the Trust's capital expenditure, cash position and Cost Improvement Programme (CIP). In response to questions from the Governors, he confirmed that agency costs had been lower during the pandemic period that in the previous year, mostly due to the reduction in bed occupancy; that there had been no penalties imposed by the regulator for provider breaches of the

agency cap in the 2019/20 financial year; and that the increased income and expenditure for the pension contributions accounted for £5 million of the year end variance.

The Director of Finance drew Governors' attention to the previously circulated report which provided a summary of the Trust's financial position at the end of the first quarter of 2020/21. He explained that the financial regime had been changed due to the pandemic, and that the Trust had received a fixed income with additional COVID costs being reimbursed. He reported that this regime was under review and the position would potentially change from 1 October, although this was yet to be confirmed. He reported that on this basis, he anticipated a breakeven position for the first six months of 2020/21. In response to questions from Governors he confirmed that the majority of staff who had been redeployed during the pandemic were now back in their original roles, and the Trust was hoping to receive the delayed overseas nursing recruits later in September; that the cash balance was significantly higher than plan because the Trust had been paid two months' cash in advance at the start of the year and this had rolled forward each month, so the underlying cash position was actually £6 million; and that uncertainty regarding the funding regime for the remainder of the year was a risk for the Trust and the NHS more widely.

The Chair thanked the Director of Finance for his reports and for the work of his team in challenging times.

CoG20/057 **Feedback from NEDs: Role of the Risk and Audit Committee in the Annual Report and Accounts Process**

The Chair welcomed Ian Metcalfe, Non-Executive Director (NED) and Chair of the Risk and Audit Committee, to the meeting. He reminded Governors that each meeting a NED was invited to attend as a way of helping the Governors in their statutory duty to hold the NEDs to account for the performance of the Board.

Ian spoke to the Governors about the role of the Risk and Audit Committee in the production of the Annual Report and Accounts. He talked about the agreeing of financial policies at the outset, the discussion of the Going Concern Statement, the receipt of the draft external audit opinion of the report and accounts, and the Letter of Representation. He explained to the Governors the role of the committee in scrutiny and challenge, especially around the use of resources and the efficiency of the organisation. He underlined the Trust's belief in putting the safety of patients and quality of care at the forefront of financial decision making. In response to a question from the Chair, Ian explained that the internal auditors' role was to look at the risks that would potentially impact on the Trust's delivery of its strategic objectives, and to advise and monitor actions to mitigate these risks.

The Chair thanked Ian Metcalfe for his presentation.

The meeting took a short break.

CoG20/058 **Strategic Estates Masterplan Update**

The Chair welcomed Ben Print, Programme Manager, back to the Council of Governors to provide an update in the Strategic Estates Masterplan.

Ben reminded Governors of the overarching masterplan, which encompassed a multi-storey car park (MSCP), an expanded emergency department (ED), aspirations for key working housing, additional care facilities and a new Hospital Support Centre. He explained that the enabling project was the MSCP which was due to go before Dorset Council's planning committee on 15 September. He reported that the papers for the meeting had been published today, and contained a recommendation that the plan was refused, primarily due to the appearance and conservation impact of the project. Ben said that the online show of support had received 1600 positive responses, and the response from the public on social media had been very favourable. He explained that the Trust had been allocated £62.5m from the Department of Health and Social Care's Health Infrastructure Plan for new Emergency Department, Intensive Care Unit, and integrated services hub. This project had a planned completion date of 2024/5 but was dependent on the MSCP project going ahead to release space for clinical developments.

Ben answered Governors' questions relating to the possibility of an appeal; the consideration of other locations and designs for the MSCP including underground parking, the current pressures on car parking, the feasibility of a Park and Ride service, and the discussions that had already taken place between the hospital and Dorset Council planners since last year.

It was noted that the Appointed Governor for Dorset Council, Tony Alford, would be present at the planning meeting and the Chair requested that a meeting be arranged for Ben, Cllr Alford and the Trust's Director of Strategy prior to the Dorset Council planning meeting on 15 September.

ACTION: LB

The Chairman said that he had strong views in favour of the MSCP and thanked those Governors who had expressed their support both in the meeting and in public. He thanked Ben and the team for their work on the project and asked Ben to return to the Council of Governors in a few months to provide a further update.

CoG20/059 **Date of Next Meeting**

The Chair noted that with the Governor elections closing at the end of September, this would be the last meeting for some Governor colleagues. He thanked Peter Wood who was stepping down after many years of service as an Appointed Governor for Age UK and said that Mr Wood would be greatly missed on the Council and especially on the Nomination and Remunerations Committee. The Chair also thanked Dave Stebbing and Tony James who had decided not to stand for re-election. The Chair extended a provisional goodbye and thank you to David Cove, Gavin Maxwell and Margaret Alsop who were standing for election in contested seats, and was pleased to announce that Tracy Glen and Simon Bishop had both been elected uncontested.

The date of the next meeting open to the public was scheduled for 2pm, Monday 9 November 2020. The Chair confirmed that this was likely to be a remote meeting, in line with the current guidance on NHS meetings and social distancing.

The Chair thanked everyone for their attendance and closed the meeting.

Council of Governors Meeting – 7 September 2020 Part One

Presented to the meeting of 9 November 2020

Minute	Action	Owner	Timescale	Outcome
CoG20/049	The Chief Executive to provide information to the Governors on the methodologies that underpin the national performance metrics.	PM	Sept 2020	**Complete.** Details circulated 29 09 20.
CoG20/058	A meeting to be arranged for Ben Print, Cllr Alford and the Trust's Director of Strategy prior to the Dorset Council planning meeting on 15 September, to discuss the multi storey car park planning application.	LB	08 09 20	**Complete.** Meeting arranged.

Title of Meeting	**Council of Governors**
Date of Meeting	**Monday 9 November 2020**
Report Title	**Lead Governor Selection - Approval**
Author	Trevor Hughes, Head of Corporate Governance

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

Summary

Lead Governors are required by NHS Improvement (NHSI) so that they can have a Governor with whom to communicate - without going through the Chairman or Trust Secretary - if there are problems in a Trust. The functions of Lead Governor, as defined by NHSI, are very narrow. However, in addition to these statutory duties the Lead Governor role at the Trust includes a range of other duties which are listed in the Lead Governor Role Description, as agreed by the Council of Governors in August 2018.

The 2020 selection process was delayed due to the pause in the governor election process in light of the COVID pandemic. The Council of Governors agreed that during the election pause David Cove should continue in his role as Lead Governor and also agreed for his term to be extended from 30 September to 16 November to cover the interim period whilst the selection process was undertaken.

Following the call for expressions of interest for the Lead Governor role, which opened on Tuesday 6 October and closed on Friday 16 October 2020, one expression of interest was received from David Cove. David is the Trust's current Lead Governor.

As there was only one expression of interest a ballot is not required. The appointment is subject to the approval of the majority of those Governors present at the Council of Governors meeting.

If appointed, David's new term will run from 16 November 2020 to 30 September 2021. This will bring the selection process back in line with the usual timetable in 2021.

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

Recommendations	The Council of Governors are requested to approve the selection of David Cove as Lead Governor for a further term of one year, from 16 November 2020 to 30 September 2021.

Title of Meeting	**Council of Governors**
Date of Meeting	**9 November 2020**
Report Title	**Chief Executive's Report, Quarter 2 – 2020/21**
Author	**Natalie Violet, Corporate Business Manager to the Chief Executive**
Responsible Executive	**Patricia Miller, Chief Executive**

1.0 Introduction

This quarterly report provides a detailed overview of how the Trust is performing against the key operational, quality and workforce standards and progress being made against the Trust Strategy.

2.0 Operational Performance

During the second quarter of 2020/21 organisations received a letter setting out the third phase of the NHS response to COVID-19, effective from 01 August 2020.

The NHS Emergency Preparedness, Resilience and Response (EPRR) incident level moved from level 4 to level 3 which meant a transition from national to regional command, control and coordination structure with local NHS organisations required to retain their incident coordination functions. The Trust continues to hold internal Incident Management Team meetings three times per week to monitor the situation with the ability to increase frequency as and when demand requires.

The third phase response identified three key priorities:

1. Accelerating the return to near-normal levels of non-COVID health services, making full use of the capacity available in the 'window of opportunity' between now and winter.

2. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID spikes locally and possibly nationally.

3. Doing the above in a way that takes account of lessons learned during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of the third phase response there were clear performance requirements set out by NHS England which include:

Elective activity to achieve:

- 70% of last year's activity by the end August
- 80% of last year's activity by the end September
- 90% of last year's activity by the end of October

Outpatient activity to achieve:

- 90% of last year's activity by the end of August
- 100% of last year's activity by the end of September

With virtual appointments being maximised wherever possible, aiming for the national benchmark of 25% of all first appointments and 60% of all follow-up appointments being delivered virtually.

MRI, CT and Endoscopy to achieve:

- 100% of last year's activity by the end of October

The Trust has been working with our System partners to submit our plans for delivery against these targets to the South West Regional Teams. It is expected the Dorset System will deliver against all targets with the exception of outpatients and non-obstetric ultrasound scans.

The Trust continues to monitor performance against the Key National Performance Indicators.

The following standards were met in September:

- The total waiting list size
- All Cancers - 31 Day Diagnosis to First Treatment
- All Cancers - 31 Day Subsequent Treatment (Surgery)
- All Cancers - 31 Day Subsequent Treatment (Radiotherapy/Other)
- All Cancers - 31 Day Subsequent Treatment (Anti-Cancer Drugs)
- All Cancers - 31 Day Diagnosis to First Treatment
- ED, DCH only and Combined with MIU

The Trust did not meet the following standards:

- Zero 52 week waits
- RTT
- All Cancers - 62 Day Referral to Treatment following an urgent GP referral
- Diagnostic Waiting Times
- Two week wait from referral to first seen
- Breast Symptomatic Two Week Wait from urgent GP referral to first seen

Table One – Performance against key standards:

Metric	Threshold/ Standard		Jul-20	Aug-20	Sep-20	Q1	Q2	YTD	Movement on Previous month
RTT *	92%	Monthly	37.2%	42.3%	46.7%	40.4%	46.7%	46.7%	↑
Waiting List Size *	15,698	Monthly	14,686	15,381	15,439	14,182	15,439	15,439	↓
52 week waits *	0	Monthly	1,030	1,328	1,651	713	1,651	1,651	↓
Diagnostics	99%	Monthly	60.1%	58.2%	60.7%	47.7%	59.7%	54.5%	↑
Cancer - 62 day	85%	Quarterly	72.7%	70.7%	68.5%	70.2%	70.5%	70.2%	↓
Cancer (ALL) - 14 day from urgent GP referral to first seen	93%	Contractual (National Operational Standard)	69.3%	63.7%	54.3%	86.4%	62.0%	72.1%	↓
Cancer (Breast Symptoms) - 14 day from GP referral to first seen	93%	Contractual (National Operational Standard)	58.1%	23.8%	13.6%	95.9%	35.1%	65.5%	↓
ED (DCH Only)	95%	Monthly	93.6%	92.3%	87.0%	92.3%	91.0%	91.6%	↓
ED (Including MIU)	95%	Monthly	96.4%	95.9%	92.7%	95.2%	95.1%	95.1%	↓

* Quarter / YTD position = month end position

** Cancer Waiting Times (CWT) will continue to alter until the Quarter position is closed as reports from treating centres are updated via Open Exeter. Diagnostic waiting times included as there could be impact on RTT and Cancer pathway standards.

3.0 Quality

During the second quarter of 2020/21 details of quality metrics recommenced, this included sepsis screening, antibiotic administration, Malnutrition Universal Screening Tool (MUST), complaints data and Venous Thromboembolism (VTE) reporting.

Although Friends and Family test data has continued to be collected internally, there has been no required uploading to the national system; this is due to recommence in November. A pilot commenced for using texts for inpatient areas from 1 September and will run for two months. Early indications show an increase in our response rate for inpatient feedback and further analysis is taking place.

There has been a slight increase in the detection of C-difficile; full analysis is taking place. Increased prescribing of antibiotics within in primary care has been flagged by the Region which will impact on rates of C-difficile.

In August we saw the start of the Stroke and Neurology Rehabilitation Pilot at Yeatman Community Hospital in Sherborne. The aim of the pilot is to support flow and continuing to deliver high quality care for patients outside of an acute hospital setting. The pilot is being undertaken as a partnership arrangement with Dorset HealthCare.

The key highlights from September were:

Positive Quality Improvement:

- There have been no Never events reported during this period
- There were no falls resulting in severe harm during this reporting period
- The recommendation rates for the friends and family test have achieved the standard required for Maternity and ED in this period
- Infection prevention sustained
- VTE just under target and improvement sustained
- Complaint responses met

Challenges to Quality Improvement:

- The completion of Electronic Discharge Summaries within 24 hours and 7 days has increased slightly in this period; however they have not achieved the standard required. This is planned QI work which will be supported by the Chief Medical Officer.
- Recommendation rates for F&F inpatients has declined for September, this is a consequence of more responses received via the texting pilot (which has different options so not fully comparable). Further analysis is taking place

4.0 Workforce

On 31 July 2020 NHS England and NHS Improvement launched the *We are the NHS: People Plan for 2020/21 – action for us all*. This follows on from the Interim People Plan published in June 2019 and sets out the actions organisations and systems should focus on for 2020/21, building on the progress made and learning from COVID-19. The Trust is now working on its local delivery plan aligned to the People Plan.

July saw the reopening of exam centres resulting in our overseas nurses being able to undertake their OSCE exams. We have achieved a total of 11 passes since reopening with a further 24 exams booked for the end of quarter 3 and into quarter 4.

Overseas recruitment was delayed with overseas nurses experiencing visa issues in their outgoing countries; we are planning for 3 cohorts however the first cohort is not due until the beginning of October. Arrival will be phased from October through to January.

We have had a successful start to our annual flu vaccine campaign; prioritising business critical areas due to vaccines arriving in batches rather than bulk. Our first batch of vaccines have now all been administered. The peer vaccination approach is a key focus this year; it is also the first year we are able to offer vaccines to staff over the age of 65.

The Trust was awarded funds from NHS Charities Together to pilot a new model of psychological care for patients and staff from the Critical Care Unit (CCU). We are working closely with Dorset Healthcare to establish a halftime clinical psychologist who will be based in CCU to provide specialist trauma support for both patients and staff. This six month pilot will be evaluated and work is already being undertaken with colleagues pan-Dorset to secure long term funding.

We have been working with our staff with long term health conditions and disabilities to hear about their experiences working in the Trust. Suggestions so far include the adoption of the Disability and Carers Passport, and building in a conversation with those off work sick for more than four weeks so line managers can ask exactly what the person wants their team to know about their condition. Further work is taking place with regular updates to our Workforce Committee.

Mental Health First Aid (MHFA) training delivery was re-established in August, we continue to deliver regular one-day and two-day courses.

A Dorset-wide project commenced in September to implement a rostering platform for all medical staff in the region. This will capture all absence and rota information. The purpose of this platform is to help us utilise the medical workforce more efficiently and to reduce locum costs.

5.0 Strategy and Transformation

The DCH Social Value Programme development is progressing aligned to the national requirements to consider wider Health Inequalities priorities as part of the third phase response. DCH draft Social Value 'Pledge', outlining our commitments as an anchor institution to help improve the wider well-being of our community, will be considered by the Trust Board in November. Discussions underway with the Dorset Integrated Care System (ICS) regarding the role of social value approach in reducing avoidable inequalities and improving health and well-being across Dorset.

September saw the culmination of over 12 months hard work with partner organisations across the Dorset ICS. This included involvement from Dorset Healthcare University Foundation Trust, University Hospitals Dorset (Bournemouth and Poole), Dorset Council, Bournemouth Christchurch and Poole Council, Dorset CCG, Public Health Dorset and NHS England and NHS Improvement. Agreement was reached on a methodology for calculating financial contributions housing developers should make to the Dorset health system when commencing large scale housing developments in accordance with Section 106 of the Town and Country

planning Act and Community infrastructure Levy. This is due to be adopted into planning policy by local authority elected members in the coming months but is set to see Dorset County Hospital significantly benefit over the next 5 years.

In September the Trust received planning permission for the multi-storey car park. This is the first step towards achieving our Estates Masterplan to improve our clinical facilities and environment for both our patients and staff. Letters of support for the scheme were received from 3 local MPs, the CCG, Dorchester Town Council, and a number of members from the Board of Governors amongst others. The value of communications was also recognised with 3,225 people signing an online register of support. This was supplemented by an extensive social media campaign, which was fronted by Dr Ian Mew, Consultant in Anaesthetics & Critical Care Medicine and Dr Stephen Meek, Consultant Emergency Physician. Work is expected to start in early 2021.

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 maintenance work across the hospital. Being able to secure this Government priority funding to improve our services for our local population is very positive news.

The long term project for an Integrated Emergency, Community and Primary Care Hub is progressing well. We held a virtual launch date with partners last month, and are developing the business case. This project is part of the DHSC's Health Infrastructure Plan (HIP2) and the Trust has been allocated £62.5m for this.

A number of Transformation projects have drawn into their final phases in this quarter, notably, the implementation of the Patient Wi-fi service, the delivery of improved protocols designed to increase VTE recording above the 95% standard and the addition of a digital Patient Activity Tracker to manage patient discharge.

The priorities of the Transformation function are currently being reviewed and realigned to meet the needs of the agreed Trust priories and will likely focus on a number of key areas going forwards, these include the creation of a sustainable digital outpatient platform, the implementation of the Quality Improvement Programme and support to key clinical infrastructure projects, Trust's cost improvement schemes and a number of COVID recovery and readiness projects.

Title of Meeting	**Council of Governors**
Date of Meeting	**9 November 2020**
Report Title	**Finance Report to 30 September 2020**
Author	Rebecca King, Deputy Director of Finance
Responsible Executive	Paul Goddard, Director of Finance and Resources

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

Summary

As a result of the COVID19 pandemic there have been a number of changes to the national finance regime to ensure Trusts have sufficient funding during the initial response period. These changes include trusts being paid fixed income each month at an amount designed to cover expected costs. In addition, trusts can claim for reimbursement of any excess costs that have been incurred (including those relating directly to the COVID19) via Retrospective Top Up funding.

This financial regime is in place for the period April to September 2020, during which time trusts are expected to achieve a break even position each month.

This report summarises the Trust's financial performance for the six months ended 30 September 2020, against the planned break even position for the period.

For the six months ended 30 September 2020, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a residual deficit of £0.077million against the NHSI plan which relates to donated asset depreciation which is not eligible for 'Retrospective Top Up' funding.

The cash balance at 30 September 2020 was £22.6 million.

Capital expenditure was £5.192 million including £1.480 million of capital expenditure relating to the COVID19 response. Capital funding for most of these costs has been confirmed by NHS England but a residual amount of £0.272m is still awaiting a decision.

Paper Previously Reviewed By
Paul Goddard, Director of Finance and Resources

Strategic Impact
NHS England is supporting trusts through the period of the COVID19 response to achieve a break even financial position, excluding amounts relating to donated asset income and depreciation.

Risk Evaluation There is a small risk that the additional funding sought by the Trust to achieve a break even position will not be paid in full by NHS England.	
Impact on Care Quality Commission Registration and/or Clinical Quality As above	
Governance Implications (legal, clinical, equality and diversity or other): As above	
Financial Implications Failure to deliver a balanced financial position could result in the Trust being put into special measures by NHSI.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	a) To note the financial position at 30 September 2020

COUNCIL OF GOVERNORS FINANCE REPORT FOR 6 MONTHS ENDED 30 SEPTEMBER 2020

	Plan YTD £m	Actual YTD £m	Variance £m
Income	102.8	108.4	5.6
Expenditure	(102.8)	(108.5)	(5.7)
Surplus / (Deficit)	**(0)**	**(0.1)**	**(0.1)**

1. YEAR TO DATE VARIANCE

1.1 The income and expenditure position at the end of the six months is a deficit of £0.077 million against a planned break even position, resulting in an adverse variance of £0.077 million.

1.2 Income levels were £5.583 million higher than plan, predominantly due to the receipt of the additional Top Up funding as mentioned above. Additional income was also received relating to the One Dorset Pathology project to offset costs incurred. Private patient income remains behind plan.

1.3 Pay costs were £5.3 million more than plan for the six months of which £4.1 million related to additional COVID19 expenditure incurred. Agency expenditure has increased recently with the increased bed occupancy and acuity of patients.

1.4 Operating non-pay costs were £0.37 million less than plan for the six months, primarily as a result of the legacy of low elective activity and bed occupancy during the first three months. Costs have risen in the second three months of the period as bed occupancy has increased and elective services have resumed.

1.5 Depreciation and PDC Dividend costs were higher than plan by £0.6 million for the six months.

2. CASH

2.1 At the end of September, the Trust held a cash balance of £22.6 million which is £17.7 million ahead of the planned position, due to the cash regime introduced by NHS England during the COVID19 response period. In April the Trust received two months' worth of "block" contract income monies paid in advance on contracts and this payment profile has continued through the subsequent months.

3. CAPITAL

3.1 Capital expenditure in the six months to 30 September 2020 was £5.192 million. Of this amount £1.480 million relates to capital expenditure as part of the COVID19 response including infrastructure works to extend ITU capacity, additional clinical equipment and IT costs to support remote working. Capital funding for most of these costs has been confirmed by NHS England but a residual amount of £0.272m is still awaiting a decision.

Title of Meeting	**Council of Governors**
Date of Meeting	**9 November 2020**
Report Title	**Mortality Report: Learning from Deaths Qtr 2 2020/21**
Author	Prof. Alastair Hutchison, Medical Director
Responsible Executive	Prof. Alastair Hutchison, Medical Director

Purpose of Report (e.g. for decision, information)
To inform the Council of Governors of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.

Summary
The Trust's SHMI fell into the 'as expected' category for the rolling years to February 2020 and March 2020, but rose fractionally out of this range for the year to April 2020. This report provides assurance that there are no other indicators to suggest standards of in-patient care are contributing to this elevation. Structured Judgement Reviews are being used by both Divisions to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses in care that are identified. This process occurs in association with the DCH Medical Examiners who review every death, and with the assistance of M&M meetings, the governance of which Miss Alison Cooper (Taunton consultant and Associate DCH Medical Director) has been reviewing and supporting.

Paper Previously Reviewed By
Quality Committee, October 2020 and the Board of Directors, October 2020

Strategic Impact
Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.

Risk Evaluation
- Reputational risk due to higher than expected SHMI
- Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement
- Clinical coding data quality is adversely affecting the Trust's ability to assess quality of care
- Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor

Impact on Care Quality Commission Registration and/or Clinical Quality
The elevated SHMI continues to raise concerns with NHS Improvement and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019.

Governance Implications (legal, clinical, equality and diversity or other):
Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016).

Financial Implications
Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.

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

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

For this Quarter's submission each Division was asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

1.1 Division of Family Services & Surgery

The Family Services & Surgery Division had 34 deaths in quarter 2 that required SJR's to be undertaken, with 9 having had a SJR completed. Between July and September 13 SJR's have also been completed from previous months.

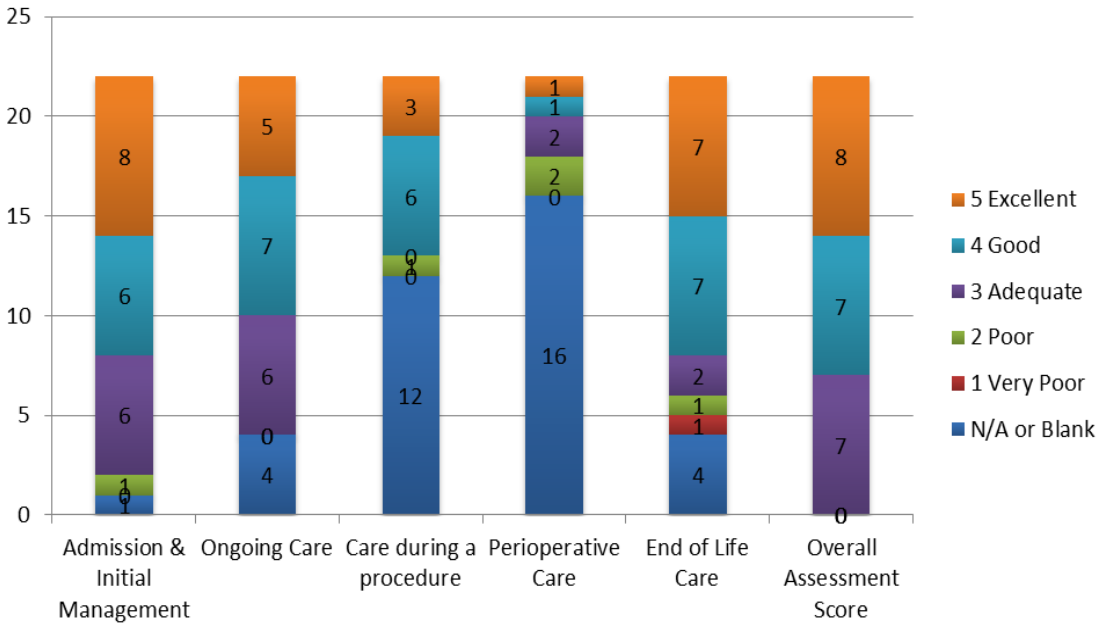
SJR Backlog: The number of incomplete SJR's for the Division as at 05/10/20 is 25:

July	August	September
6	4	15

The available notes have been allocated to Clinical staff to ensure these are completed.

Feedback from SJR's completed in quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or blank	1	4	12	16	4	0
1 Very Poor	0	0	0	0	1	0
2 Poor	1	0	1	2	1	0
3 Adequate	6	6	0	2	2	7
4 Good	6	7	6	1	7	7
5 Excellent	8	5	3	1	7	8



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	4	1	7	8

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (< 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	3	17

Learning from structured judgement reviews:

Areas of good practice:

a) Admission

- Early consultant involvement
- ICU consultant intubating patient in resus at 11pm (COVID rota)

b) Ongoing

- Regular consultant reviews especially gastroenterology
- Excellent consultant delivered care
- Excellent Critical Care Outreach reviews and regular input for ill patients

c) Procedure

- Good documentation procedures

d) Perioperative care

- Nil specific

e) EOL care

- MDT involvement for palliative care
- 2nd consultant opinion

Areas for Improvement:

a) Admission

- No cardiovascular or respiratory exam documentation on a number of symptomatic patients – for re-discussion at HMG
- Patient community DNAR. Noted on anaesthetic chart by Con but form not filled out. Ended up PEA arrest in ICU 5 rounds unnecessary CPR – Presentation CGM
- No social history on clerking patient with ascites ?Cancer. Noted by consultant next day patient heavy drinker. Secondary to ALD – Newsletter
- Patient seen by F1 doctor on admission. Discussion with SPR but not seen by anybody senior until the next morning when the anaesthetic team were fast-bleeped to the stroke unit – Medical CGM referral.
- Lack of Elderly Care reviews for orthopaedic patients – for discussion HMG

b) Ongoing

- Patient developed line sepsis after a 6 day old femoral line was used for TPN – referred for RCA but has been discussed with CCG as SI? Risk/CD decided not for RCA.
- Deteriorating pancreatitis patients need earlier admission to ICU – CGM presentation
- Limited Elderly Care review of orthopaedic patients.

c) Procedure

- Nil

d) Perioperative

- Patient with acute abdomen. NG not placed prior to intubation. Aspirated on induction. 1.2L then drained from stomach. Died in ICU but aspiration not thought to have contributed significantly to death – CGM presentation for learning
- Number of patients had no record of P-Possum score pre-op. Less consultant anaesthetic discussions documented especially at night. Reduced number consultant anaesthetist involvement – CGM presentation and ask NELA lead to correlate with recent data (done).
- Failure to document post-op instructions or DNAR/DNE - CGM

e) EOL care

- Patient with multiple comorbidities and undergoing palliative chemotherapy. Previous DNAR. Noted on anaesthetic chart by consultant and patient admitted ICU. But DNAR form not completed. 5 rounds unnecessary CPR on ICU – Presentation CGM

f) Notes

- Loose &/or photocopied

Identified Themes:

- Poor/ absent CV or Respiratory examinations for surgical patients
- Inadequate Orthogeriatric input for orthopaedic patients.
- Reticence in filling out DNAR/DNE
- Benefit of CCOT
- Non-Elective Laparotomy Audit; ?deteriorating performance – Less P Possum documentation/ con anaesthetist discussion and involvement/ post op instructions

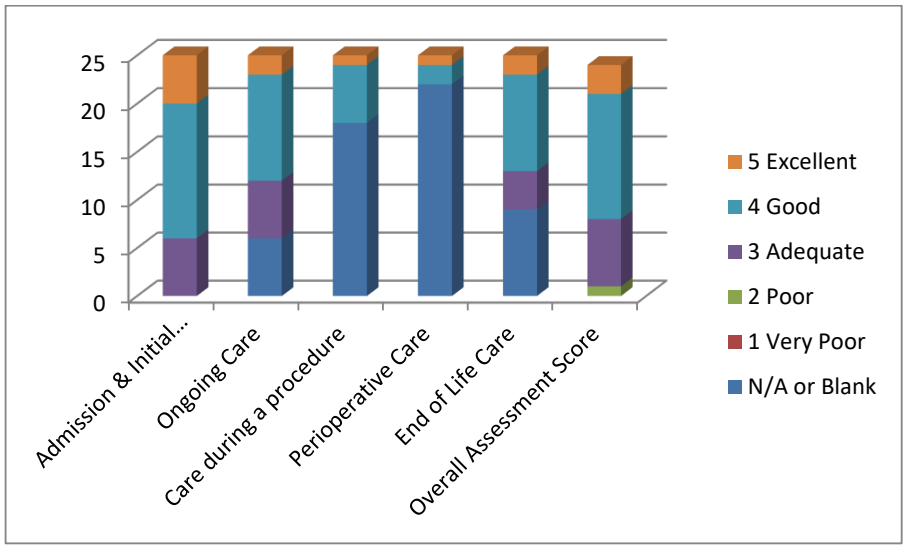
Report completed by:
Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care

Structured Judgement Review Results

The Urgent and Integrated Care Division had 128 deaths in quarter 2, with 14 having had a SJR completed. Between July and September, 11 SJR's have also been completed from previous months.

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	6	18	22	9	1
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	1
3 Adequate	6	6	0	0	4	7
4 Good	14	11	6	2	10	13
5 Excellent	5	2	1	1	2	3



Overall Quality of Patient Record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	8	10	6

Poor handwriting and filing. Evidence on electronic systems of failure to capture relevant clinical information but hasn't caused poor care.

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	1	0	1	2	21

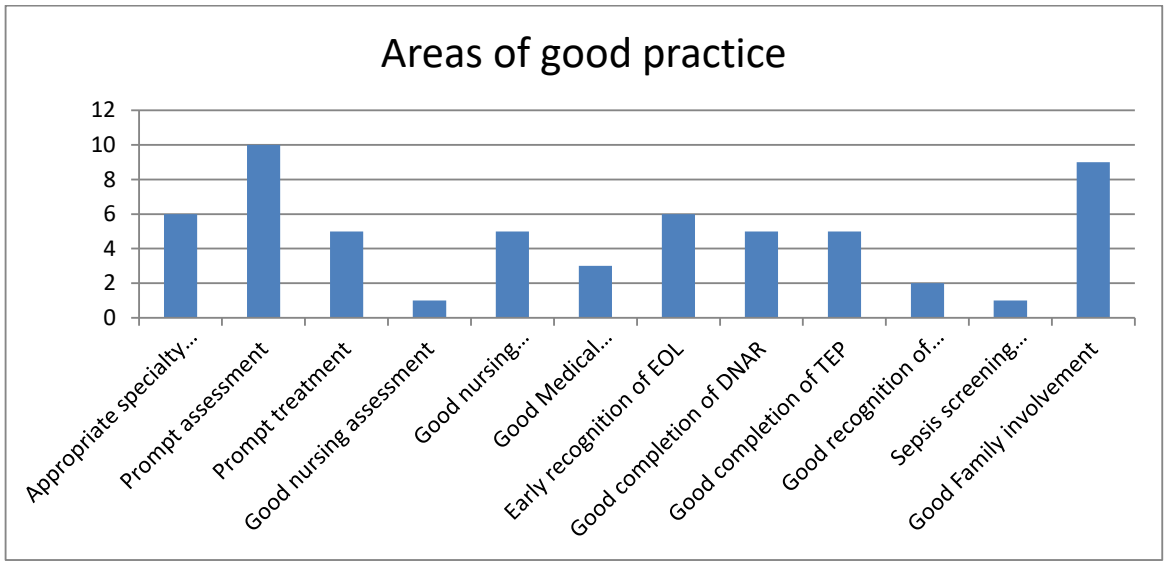
SJR scoring 2: This was a difficult case - patient admitted with one diagnosis, then through the admission developed both hypernatraemia and hypokalaemia of unknown cause with aspiration pneumonia. The cause of death of urosepsis was not felt to reflect the patients symptoms, and there is no bacteriological evidence that urosepsis was the cause.
Case review has been completed and due to be heard at HMG Panel 29/10/2020.

SJR Backlog
The outstanding SJR's for the Division as at 05/10/20 is 11:

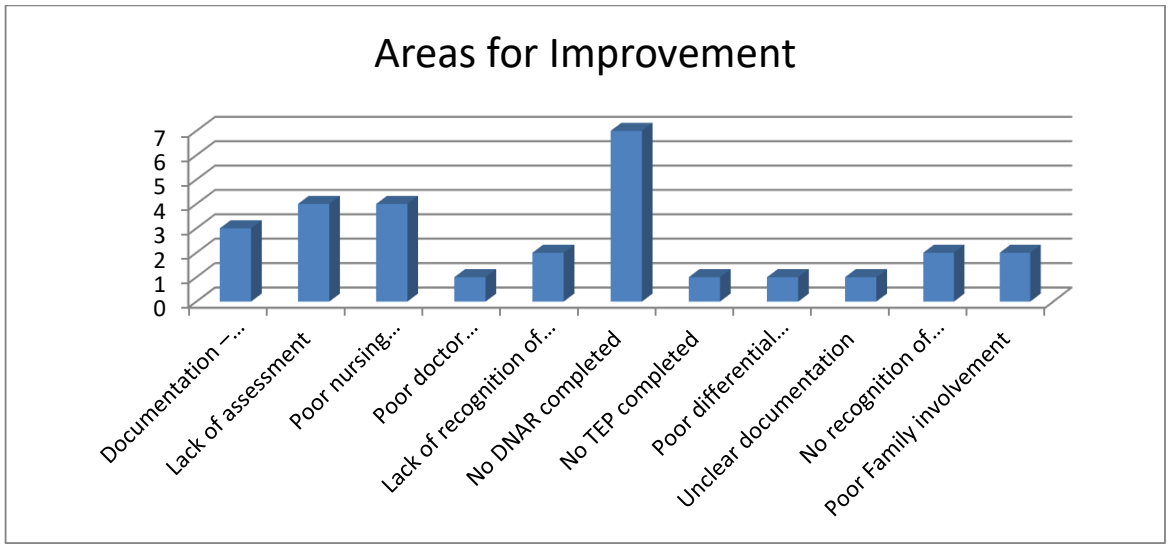
July	August	September
2	3	6

The available notes have been allocated to Medical and Nursing staff to ensure these are completed.

Clinical Key Themes
Areas of good practice:



Areas for Improvement:



Learning and Actions from SJR's:
All learning and outcomes from Governance and M&M meetings will be appropriately followed up now a permanent Quality Manager is in post.

21/08/2020 SJR to be shared at Acute Medicine Governance in September and learning to be feedback. Chaser due to be sent in October for Outcome. SJR demonstrated a common theme around evening admission. Patient should have had at least discussion around ceiling of care, but no documentation occurred despite a subsequent consultant review. The patient later had an in hospital cardiac arrest with resuscitation despite frailty and advanced dementia.

25/09/2020 SJR to be shared at Governance in October and learning to be fedback. Chaser will be sent in November for Outcome. This patient attended with a community DNAR which was recognized in the clerking in ED, however no Trust DNAR form was completed until 7 days after admission. A DNE form was completed 4 days after admission and on the form it states that we were not aware that an advanced treatment plan was available. SJR to be highlight in October governance, the trust requirement to complete a DNAR form every time that a patient enters the trust with a DNAR form in existence. Whilst in this case the patient did not receive unnecessary resuscitation this is a current concern in the division. Positive note - an excellent care record was noted in this case.
14/09/2020 SJR to be shared at next oncology M&M to raise awareness of the issues around advance care planning. Learning to be fedback following meeting. Chaser will be sent in November for Outcome.
21/09/2020 2nd SJR requested due to lack of management of persistent hypotension and poor fluid balance management/documentation. Second review to be completed in October
15/09/2020 SJR to be discussed at Care of the Elderly M & M in October to discuss the poor recognition of the DNAR for this patient. Learning and actions to be fedback following October's meeting. Chaser will be sent in November for Outcome.
18/09/2020 SJR to be discussed at Cardiology Governance meeting in October To discuss the absence of a ceiling of care or DNAR discussion with the family subsequent to PCI showing critical 3 vessel disease on the background of ischaemic cardiomyopathy with an EF of <20% with global hypokinesia. Learning and actions to be shared following the meeting. Chaser will be sent in November for Outcome.
06/07/2020 SJR completed. Family's concerns to be followed up with SWAST as part of PALS process.
21/08/2020 SJR to be reviewed at ED governance meeting in September to reflect on the pathway of patient. Outcome and learning to be shared following meeting. Chaser will be sent in October for Outcome.
18/09/ 2020 SJR found that the care provided during the PCI to the point of death and review afterwards represents excellent care of this patient. SJR to be shared at Cardiology Governance meeting October. Chaser will be sent in November for outcome.
09/09/2020 SJR completed and shared with Day Lewis Ward to feedback to staff regarding communication: Patients that have DNAR orders in place and any relocation of wards should include a plan for the management of notes/documentation Outcome following meeting: Team have reflected on the case. Measures in place: i.e orientation to place, update on handover sheets, safety brief.
SJR shared at Stroke steering group 23/06/2020 to discuss visibility of DNAR form. Feedback from clinicians advised this was in hand.
22/09/2020 SJR to be shared at next ED/Acute Medicine M&M meeting with regard to clarity of communication and the evaluation of patients prior to sedation when on EOL pathway. Chaser will be sent in November for outcome.

11/09/2020 - SJR shared with Ilchester

The patient was an LD patient and we noted:
• The MUST risk assessment was crossed through as if not applicable
• Whilst there was a fluid chart it was not a fluid balance chart – no adding up or real purpose to it
• There were observations recorded in the notes representing a deterioration but this had not been entered onto VitalPac
We also noted:

- Good involvement of family and carers, and good documented evidence of 2 hourly rounding.

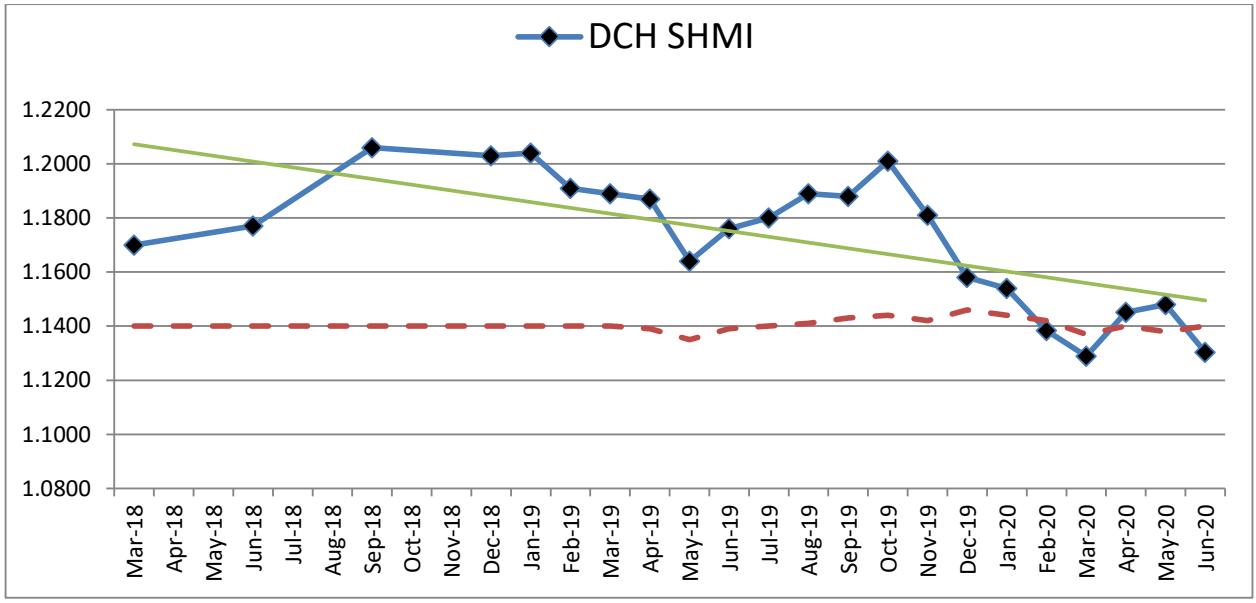
Chaser has been sent to confirm outcome.

Stacey Notley – Quality Manager
Sonia Gamblen – Divisional head of Nursing & Quality

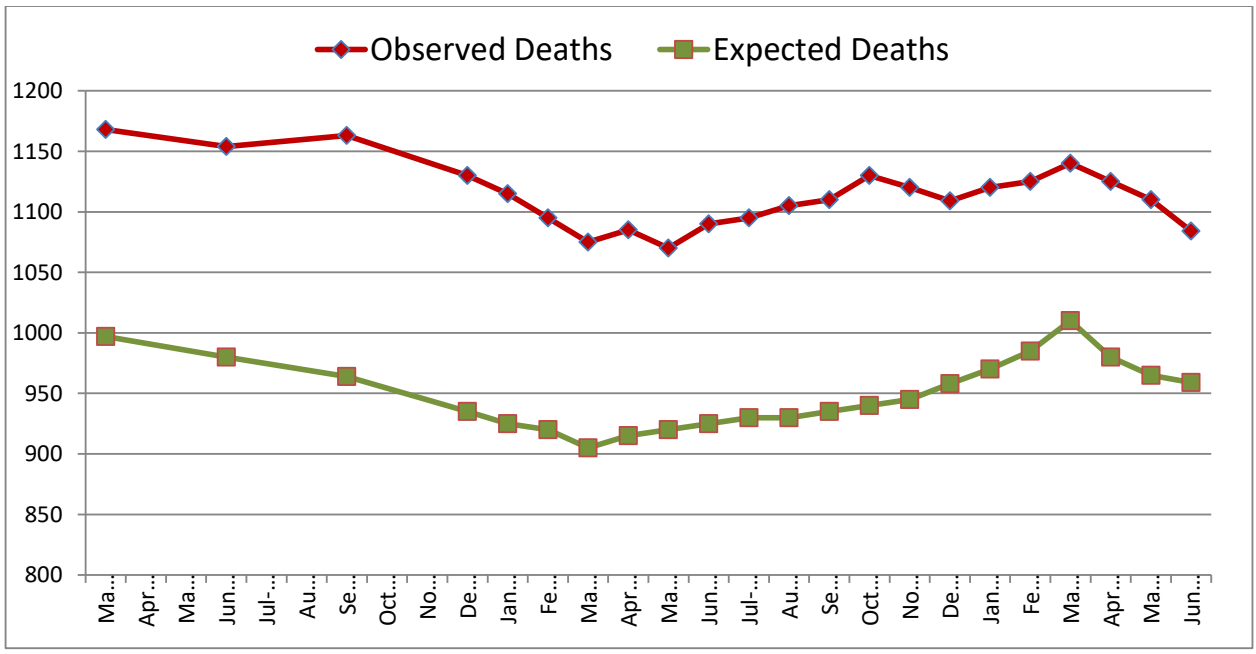
2.0 NATIONAL MORTALITY METRICS

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is provided by NHS Digital as s series of 12 month rolling periods, but 5 months in arrears. It takes into account all diagnostic groups and in-hospital deaths, and also deaths occurring within 30 days of discharge from hospital. The SHMI for the rolling years from October 2019 through to June 2020 has been reducing with the latest figure at 1.130 (June 2020) which is in the 'as expected' range (below red dashed line). Coding during March and April was interrupted by the majority of coders being unable to work on site, and DCH not yet having an electronic patient record to access.



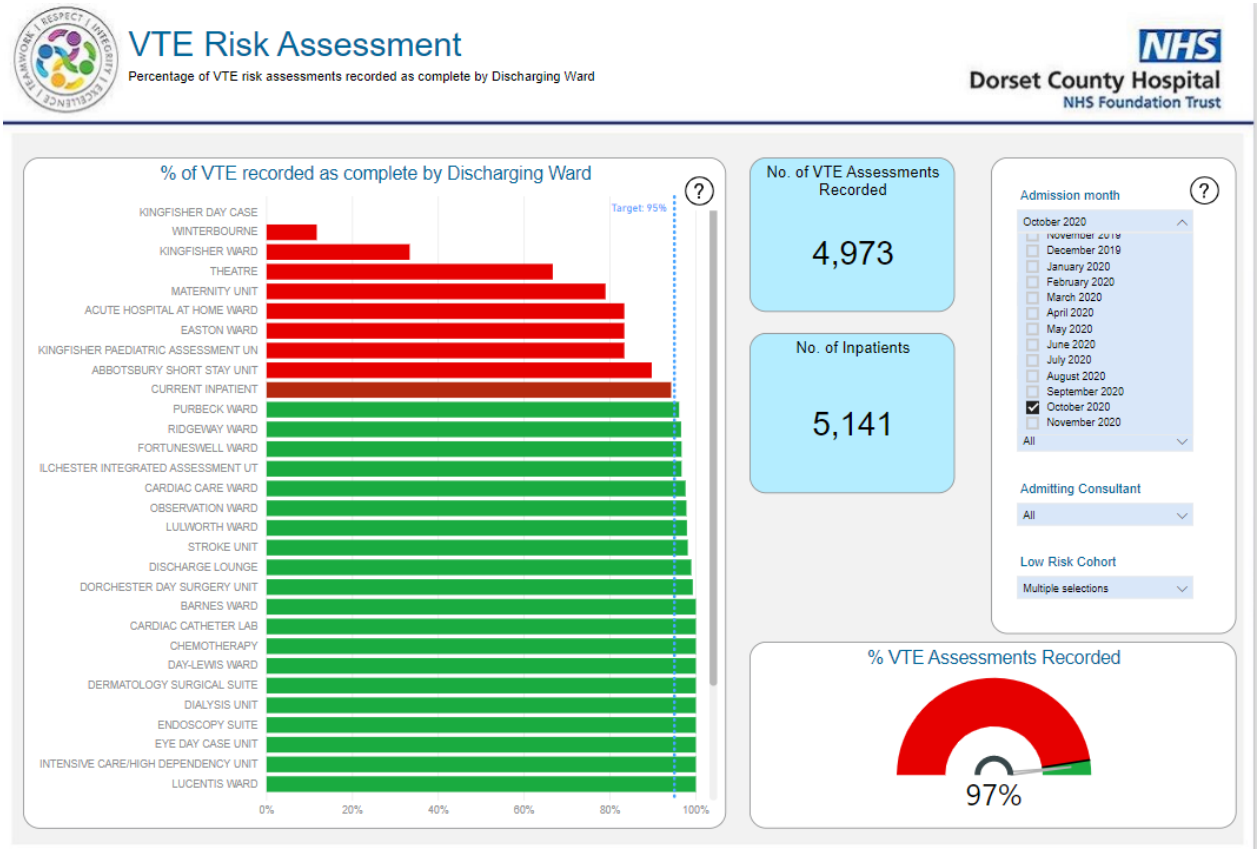
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding data). The chart below shows observed and expected deaths (predicted based on DCH coding) over the past 2 years (rolling years from March 18 to April 20).



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other national data which might relate to standards of care and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trust performance.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing. DCH VTE risk assessments reached 94% in August and achieved the 95% target for September 2020.



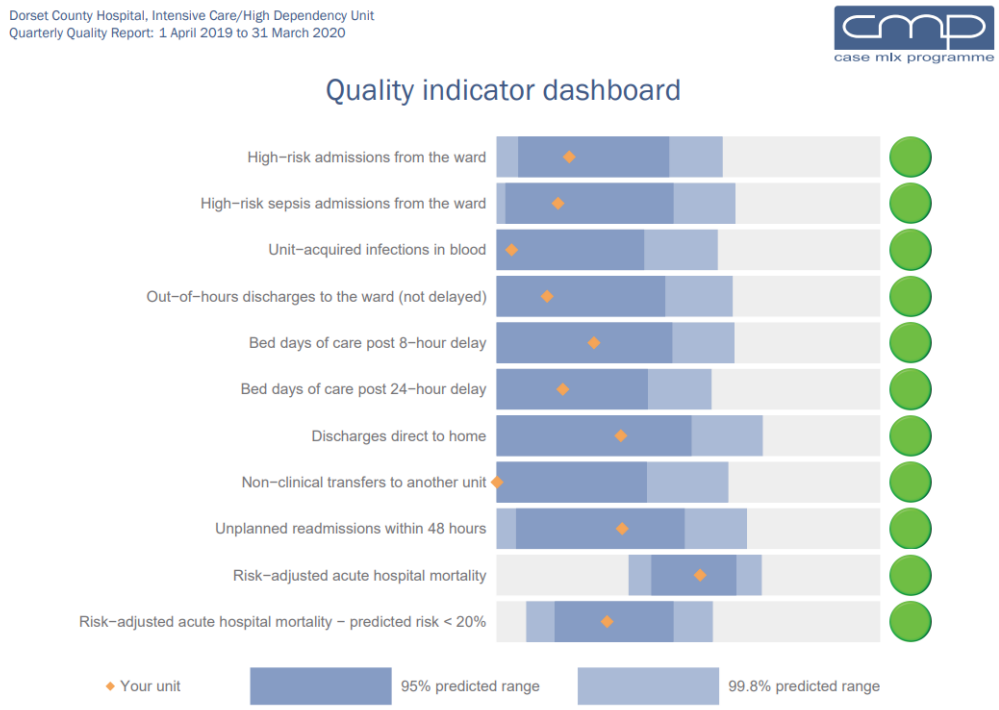
3.1 NCAA Cardiac Arrest data

12 month Cardiac Arrest data for 01 April 2019 to 31 March 2020 was published in June 2020, and included in the previous Q1 report. The next data publication is due in November 2020.

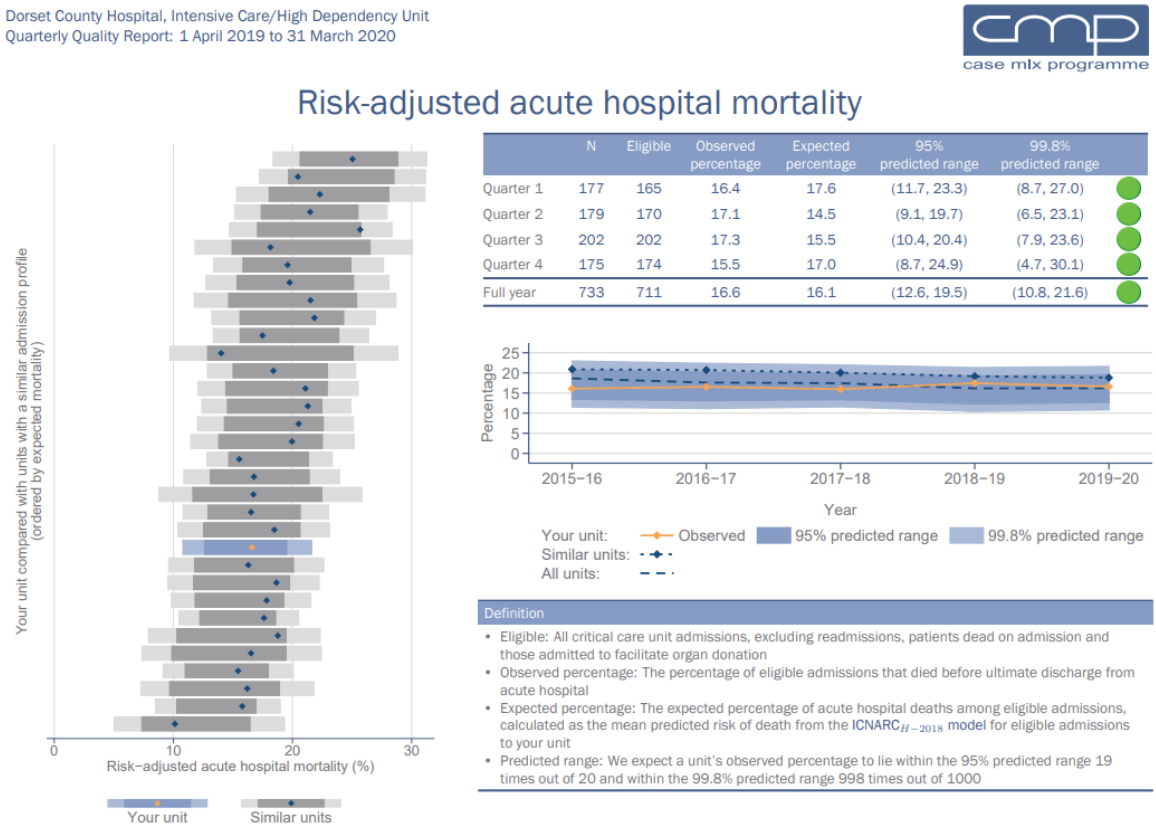
3.2 National Adult Community Acquired Pneumonia Audit latest data - published November 2019

No new data for 2020 as yet.

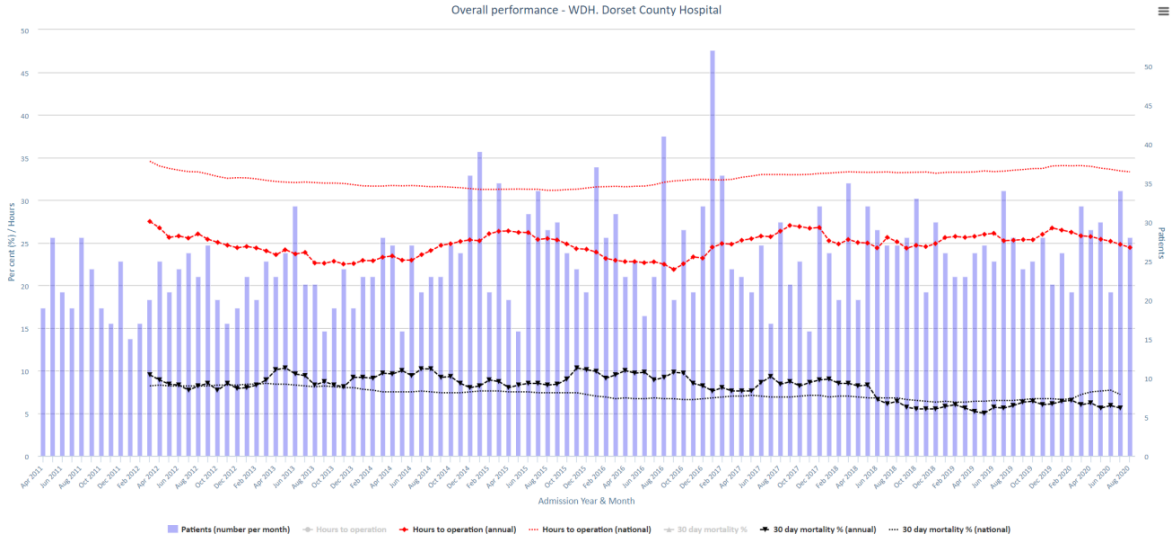
3.3 ICNARC Intensive Care survival latest data published 30 June 2020



The chart below shows the “risk adjusted acute hospital mortality” following admission to the critical care unit. It compares observed and expected death rates in a similar fashion to SHMI.



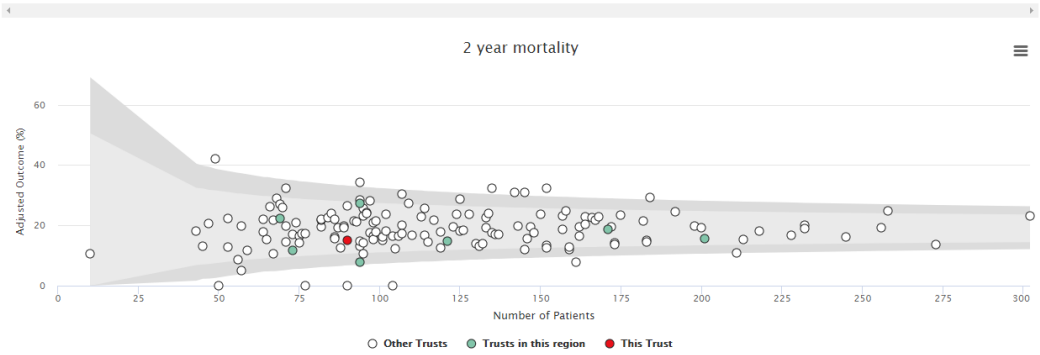
3.5 National Hip Fracture database to June 2020



Time from admission to operation remains significantly better than the national average (25.2 vs 33.6 hours), with 30 day mortality at 5.9% versus the national average of 7.7%.

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available data for 2017/18 – 2 year survival compared to all other NHS Trusts.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	90	15.1%	15.6%

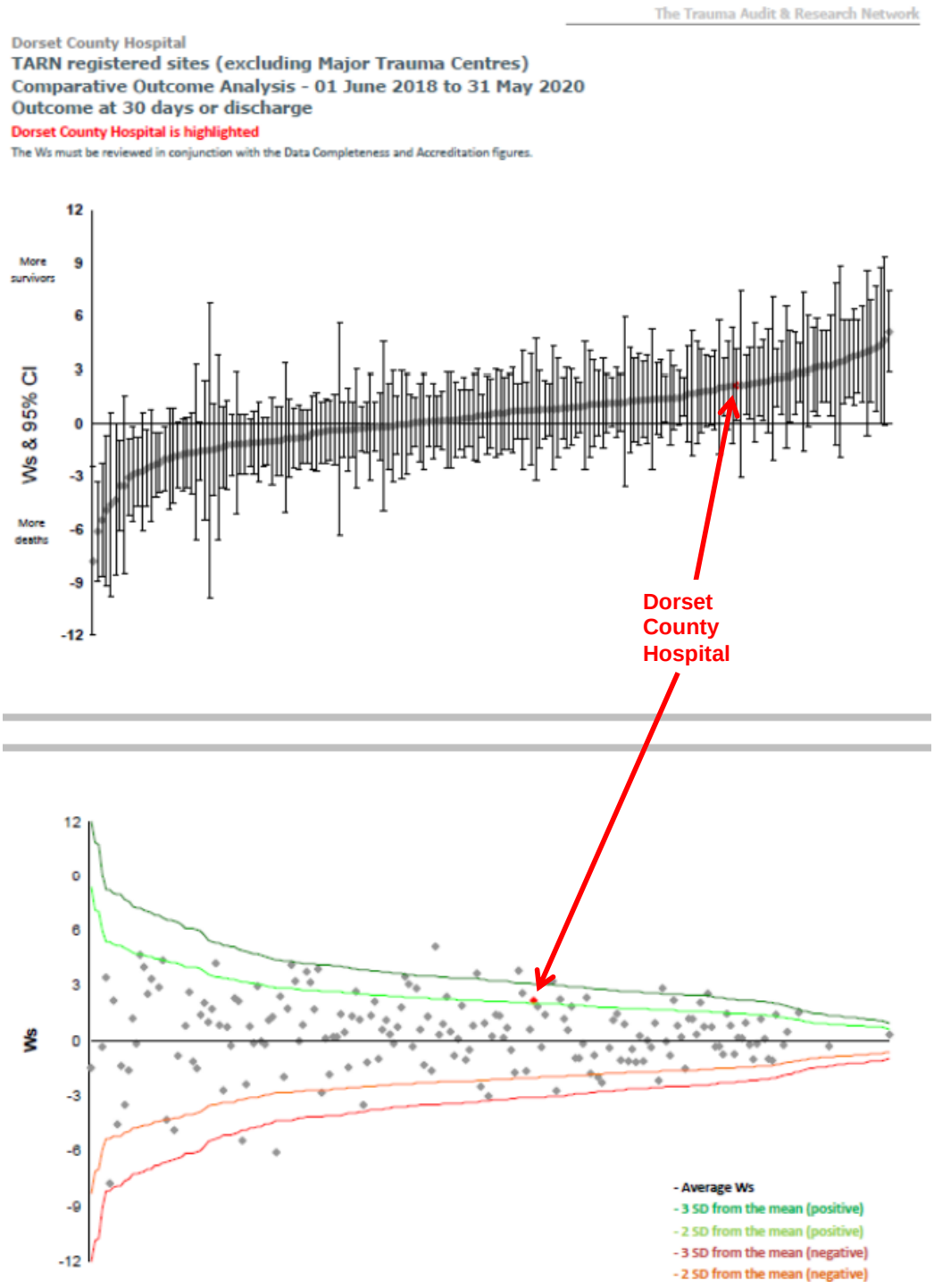
3.7 Getting it Right First-Time reviews in Q1

No GIRFT reviews were undertaken at DCH during this quarter. Since March 2020 all visits were suspended because of COVID-19. Virtual visits are expected restart in Q3, subject to COVID wave 2.

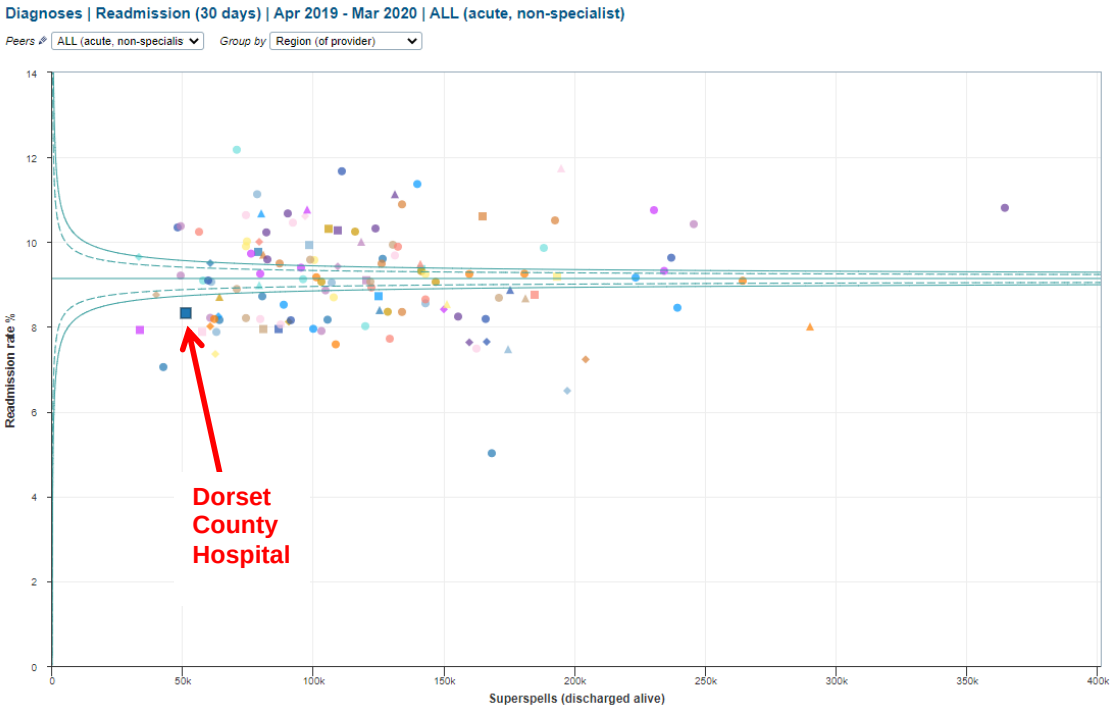
Full reports from previous GIRFT visits are available, and feedback from each review has previously been very positive. Action plans have been developed and are being worked through at present.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. A summary of the latest published data (to 31st May 2020) is shown below, and in both graphs higher is better:



3.9 Readmission to hospital within 30 days, latest available data (Dr Foster) – lower is better



3.10 Dr Foster Safety Dashboard

This dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during their in-patient stay. Where the confidence intervals include the national mean there is no difference from the national average. DCH has a higher caesarean section rate than expected (7 versus 2) and a lower number of decubitus (pressure) ulcers (209 versus 242). In this latest data "Deaths in Low Risk diagnosis groups" has also shown an alert and each of these cases is undergoing an SJR. Preliminary data suggests that the diagnosis group is incorrect in several of these cases but a full analysis is awaited.

Quality **Safety**

Patient Safety Indicators

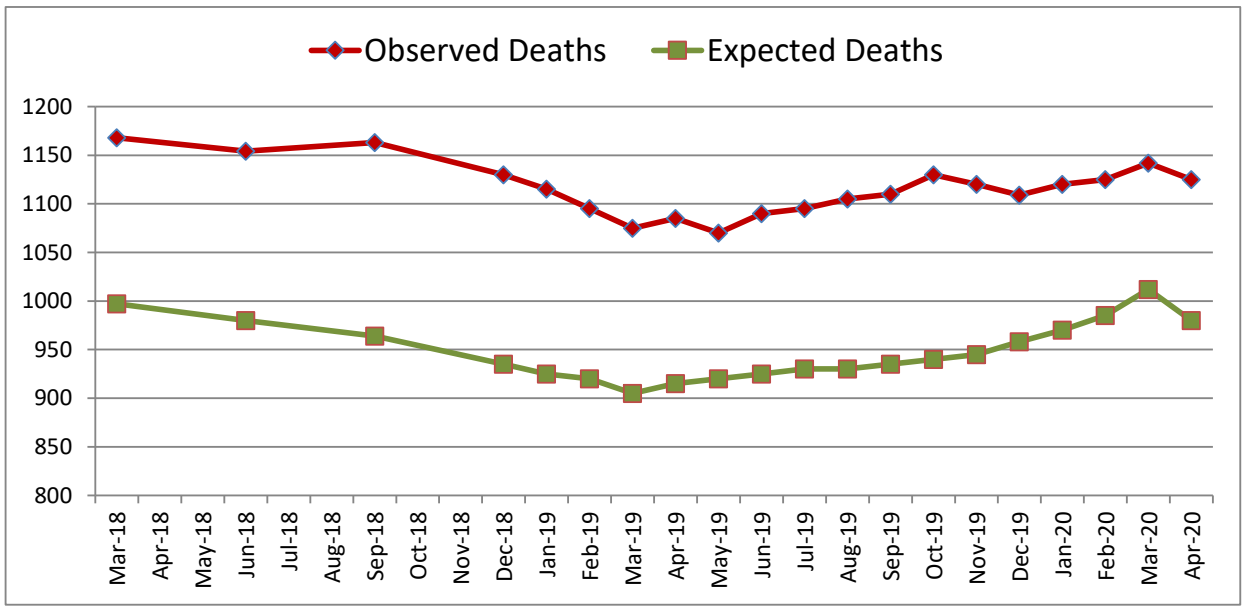
Period: 12 months (Apr 19 to Mar 20) | Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	41170	62	65.1	1.5	1.6	95.3	
Deaths after surgery	231	21	15.8	90.9	68.3	133.1	
Deaths in low-risk diagnosis groups	21422	17	9.4	0.8	0.4	181.6	
Decubitus ulcer	4906	204	269.0	41.6	54.8	75.8	
Infections associated with central line	7715	0	0.5	0	0.1	0.0	
Obstetric trauma - caesarean delivery	419	7	1.8	16.7	4.4	383.9	
Obstetric trauma - vaginal delivery with instrument	134	9	9.0	67.2	67.1	100.1	
Obstetric trauma - vaginal delivery without instrument	789	20	22.6	25.3	28.6	88.6	
Postoperative haemorrhage or haematoma	16257	5	5.7	0.3	0.4	87.1	
Postoperative hip fracture	21303	1	1.2	0.0	0.1	86.9	
Postoperative physiologic and metabolic derangement	14194	2	1.9	0.1	0.1	105.2	
Postoperative pulmonary embolism or deep vein thrombosis	16395	39	37.5	2.4	2.3	104.1	
Postoperative respiratory failure	13098	9	10.2	0.7	0.8	88.2	
Postoperative sepsis	289	1	4.0	3.5	13.9	24.9	
Postoperative wound dehiscence	431	0	0.3	0	0.8	0.0	

4.0 CODING

4.1 Depth of coding

The DCH depth of coding for Charlson Co-morbidities remains around the lowest in the country. However the Trust's expected death rate had been rising over the past 12 months suggesting that coding accuracy overall is probably improving. The figure for the rolling year to April has dropped, and may in part reflect unpredictable changes resulting from COVID. The graph below plots Observed (actual) deaths and Expected deaths against rolling 12 month time points.



4.2 PWC Artificial Intelligence

PWC have produced an AI model to assist Trusts in understanding technical issues relating to elevated HSMR and SHMI figures. Initial discussions with PWC were halted on grounds of cost in 2019, but during Q4 these were restarted after a reduced price offer and discussions between the Medical Directors of DCH and The Royal Wolverhampton Trust (a current client of PWC). RWT were very complimentary about PWC's assistance which they feel is largely responsible for their SHMI improvement over the past 12 months from the highest in the country to well within the expected range for the past 3 published months of data.

Discussions within the Executive Team led to a request for PWC to submit an options paper for future collaboration and pricing, which has been accepted in principle, but PWC have recently indicated that they may no longer be able to provide this service.

5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:
1. Recognition and management of AKI
2. Poor quality of some admission clerking notes, particularly in surgery
3. Morbidity and Mortality meetings - standardization and governance (see 6.0 below)

6.0 MORBIDITY and MORTALITY MEETINGS

Dr. Alison Cooper has returned to DCH as an Associate Medical Director for 1 day per week, with responsibility for M&M meeting governance. She commenced in post on 02/07/20. All departmental Clinical Leads have been asked to ensure that M&M meetings are continuing on a regular basis during the CoVID-19 pandemic (depending on the number deaths within each department), using the Royal College of Surgeons M&M meeting Best Practice document as their template.

See appendices:

1. M&M Agenda template

2. M&M Case selection template

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 9 new Coroner's inquests being opened in the period 01.07.20 – 30.09.20. All Inquests that were listed were adjourned due to CoVID-19 restrictions. Cases have been listed for Pre Inquest Review hearings in October 2020, which it is hoped can be undertaken virtually where the family or the staff has no objection. We have undertaken one Pre Inquest Review via this route in September, and attended one at Court as that was the family's preference.

We currently have 46 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 2 inquests were heard as Documentary hearings in quarter 2.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. We now have a virtual court room set up within Trust Headquarters so that staff can attend inquests virtually. Free training has previously been provided, via our Trust Solicitors, around Inquest Hearings and statement writing which was well attended by a variety of staff groups. We will consider re-running some of these courses to assist with the change in processes in holding hearings virtually.

8.0 LEARNING FROM CLAIMS

See appendix 3

9.0 SUMMARY

SHMI remains higher than expected, but with evidence of a clear trend to improvement over the past 6 (arguably 24) months. No other metrics of in-patient care suggest that excess mortality is occurring at DCH.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are being improved, and for the first time this report includes Divisional descriptions of their progress.

Morbidity & Mortality Meeting
Specialty
Meeting Time and Date
Meeting Venue

AGENDA

1.	**Welcome and Apologies for Absence:**		Chair
2.	**Reminder to Sign In**		All
3.	**Review of Actions from Previous Meeting**	Enclosure	Chair
4.	**Cases for Discussion**	Presentation	
5.	**Feedback from Division**		Chair
6.	**A.O.B.**		
7.	**Date of Next Meeting**		

Case Presentation and Discussion

- Chair to allocate preparation and presentation of cases to staff.
- Cases should not be presented by doctors involved in case.
- Patient identified by hospital number. Clinicians involved not identified.

Standardized approach to all cases

- PATIENT – age, comorbidities, working diagnosis, operation if appropriate, adverse outcome
- EVENTS – chronological summary of events that led to adverse outcome. Relevant vital signs and investigations
- ANALYSIS – summary of contributing factors.

Consider:

- *Human factors*: *e.g.*Lack of communication, lack of knowled**ge**, failure to follow guidelines, lack of teamwork, fatigue, failure to escalate or ask for help, prescription error
- *System factors*: *e.g.*Equipment failure, insufficient staffing, operational pressures
- *Patient factors:* *e.g.*Co-Morbidities e.g. BMI
- LEARNING POINTS

Case Discussion by staff present

- Areas of good practice
- Aspects of care that good be better both clinical or organizational.
- Was there preventable harm?
- Does there need to be a formal investigation and Duty of Candour?

Summary excel spread sheet completed and stored in Specialty folder within the Mortality & Morbidity Management folder on S:Drive.

Morbidity & Mortality Case Selection

Case selection

- Morbidity – Review of SJR
- All cardiac arrests
- Patient safety incidents which resulted in moderate to severe harm, or near misses (where patients could have been harmed)
- Never Events (as per NHS lists)
- Post-operative/post procedure complications
- Unexpected HDU/ ITU admissions
- Return to theatre within the same or recent admission
- Medication errors
- Deteriorating patients
- Unplanned readmission within 30 days
- Learning from excellent care

Consider issues raised from complaints and National Audits

Organisational requirements for Mortality and Morbidity meeting

- A chair for the meeting should be nominated. Their role is key to creating positive learning, collaboration and collegiality and contributes to building a strong safety culture. A deputy should be appointed to cover when necessary.
- Should be held on a regular basis not less than quarterly, frequency to depend on speciality and number of incidents requiring review, and should be included within existing Governance meetings
- Room must be large enough to accommodate staff with access to appropriate audio visual equipment for virtual attendance
- Member of risk management team or service manager to attend. If no admin support, facilitate recording data with help of clinician
- Excel summary to be stored in Specialty folder within the Mortality & Morbidity Management folder on S:Drive to be accessed by the Care group and Division.
- Attendance at meetings to be recorded and included as necessary part of Appraisal. It is a requirement expected that attendance at 25% of meetings per annum is achieved. In small departments where there are too few clinicians for meaningful review of cases, attendance at regional M&M is advised.
- Protected time. Service managers will ensure that clinical activity is reduced and that attendance is included in job planning to ensure attendance and accountability

Who should attend?

This is a highly educational forum and can be included as part of medical and nursing trainees and medical student teaching

Core attendees include:

- Clinicians, doctors in training, nurses, midwives and other healthcare staff

Encouragement where appropriate for:

- Allied health professionals , clinical pharmacists, secretaries ,ward clerks, management representatives

APPENDIX 3

LEARNING FROM CLAIMS

During the period 01.07.2020 – 30.09.2020, 24 new claims were recorded on Datix. Of those, 13 are at the disclosure of records stage (so potential claims), 1 claim is under consideration for a settlement (offer to settle submitted by the claimant) and 9 claims have been opened in the following specialities:

	Respiratory Service	ED - Minors Service	General Surgery Service	Ear, Nose and Throat (ENT) Service	Ophthalmology Service	Gynaecology Service	Obstetrics Service	Total
2020 07	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**
Non-Clinical	0	0	1	0	0	0	0	1
2020 08	**1**	**0**	**0**	**1**	**1**	**0**	**2**	**5**
Unknown	0	0	0	0	0	0	1	1
Otorhinolaryngology	0	0	0	1	0	0	0	1
Paediatrics	0	0	0	0	0	0	1	1
Ophthalmology	0	0	0	0	1	0	0	1
Respiratory	1	0	0	0	0	0	0	1
2020 09	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**3**
Emergency Department	0	1	0	0	0	0	0	1
Gynaecology	0	0	0	0	0	2	0	2
Maternity	0	0	0	0	0	0	1	1
Totals:	1	1	1	1	1	2	2	10

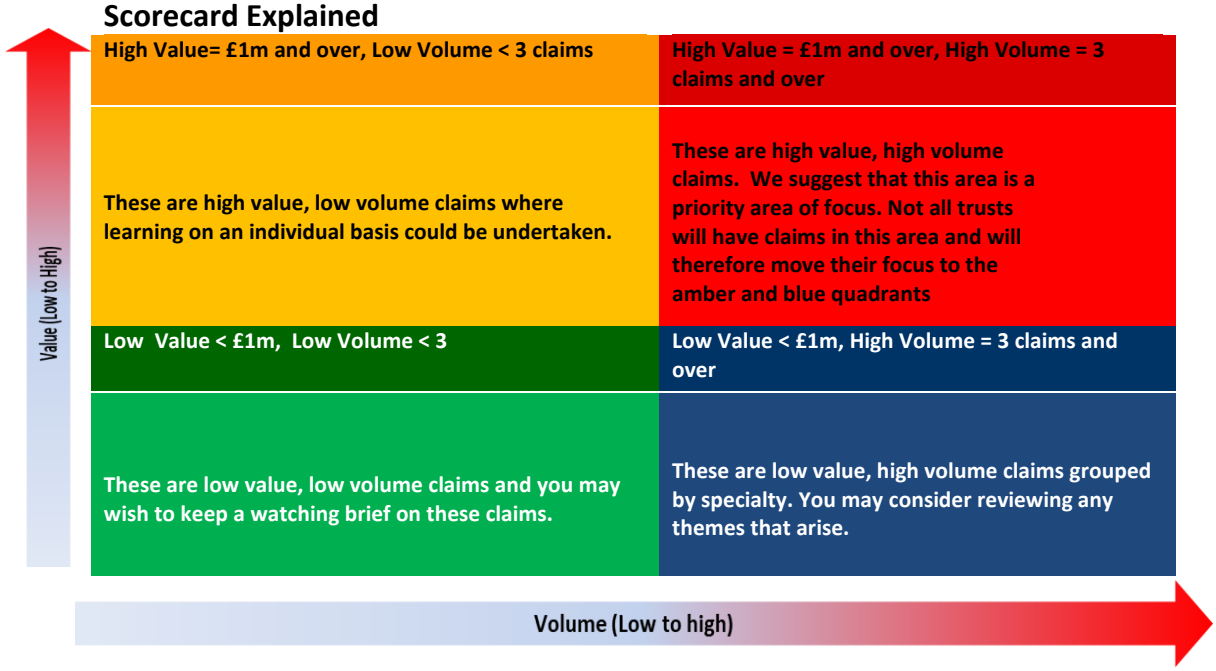
During the same period:
1 case was withdrawn following exchange of witness or expert reports
5 cases the limitation period expired (Three year period)
1 case pending formal claim – disclosure of records completed

Dorset County Hospital NHS Foundation Trust

The data presented in these spreadsheets is provided to Trusts to consider their claims and learning that can be determined by using different approaches according to the quadrant description presented below.

Selection Criteria: CNST claims received with an Incident Date between 01/04/2010 and 31/03/2020
Total number of claims for this Trust: 242. Total value of claims for this Trust £35,311,841
Data correct at: 31/08/2020

Scorecard Explained



Qualifications for the Data Presented in this Scorecard

1. Criteria for Claims Selection
The data has been extracted from the NHS Resolution Claims Management System (CMS). It covers the years detailed above in the "Selection Criteria" section. A claim will appear if the incident occurred within those years.

2. Claim Values*
The value of a claim is the total of:
The amount paid in damages, claimant costs, defence costs and, for open claims, the estimated value of the claim at the time when the data was taken from CMS. The date in which the data was taken from CMS is defined "Data Correct at" section.

3. Data Groupings
Claims within Obstetric specialty may contain some Gynaecological claims. These can be identified in the "Specialty" column in the zone data sheet.

Selection Criteria: CNST claims received with an Incident Date between 01/04/2010 and 31/03/2020
Total number of claims for this Trust: 242. Total value of claims for this Trust £35,311,841
Data correct at: 31/08/2020

	Nr	Value
Cardiology	1	£ 1,920,000
Paediatrics	1	£ 1,690,000
Grand Total	2	£ 3,610,000

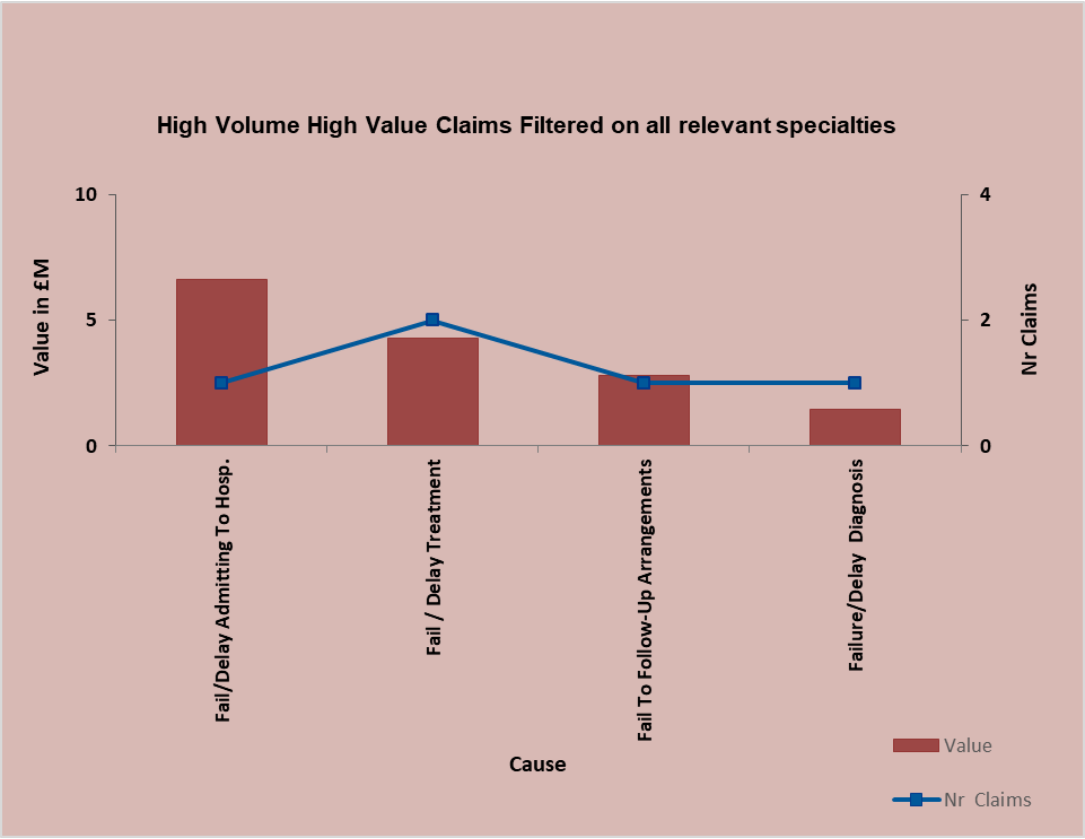
	Nr	Value
Emergency Medicine	5	£ 15,194,222
Grand Total	5	£ 15,194,222

	Nr	Value
Chemical Pathology/ Biochemistry	1	£ 270,000
Dentistry	1	£ 2,300
Endocrinology	1	£ 184,829
Geriatric Medicine	2	£ 22,980
Intensive Care Medicine	1	£ 85,887
Neurosurgery	1	£ 48,044
Oncology	1	£ -
Oral & Maxillo Facial Surgery	1	£ 85,000
Other	1	£ 53,149
Renal Medicine	2	£ 48,000
Respiratory Medicine/ Thoracic Medic	2	£ 401,250
Rheumatology	2	£ 22,061
Surgical Speciality - Other	1	£ 24,994
Grand Total	17	£ 1,248,494

	Nr	Value
Anaesthesia	6	£ 51,911
Cardiology	5	£ 560,606
Dermatology	4	£ 84,633
Emergency Medicine	34	£ 3,200,726
Gastroenterology	5	£ 108,146
General Medicine	12	£ 622,770
General Surgery	26	£ 2,005,092
Gynaecology	11	£ 326,186
Histopathology	5	£ 275,310
Obstetrics	25	£ 1,754,190
Ophthalmology	12	£ 572,043
Orthopaedic Surgery	39	£ 3,053,139
Otorhinolaryngology/ ENT	8	£ 318,480
Paediatrics	3	£ 79,716
Radiology	7	£ 962,050
Urology	10	£ 248,391
Vascular Surgery	6	£ 1,035,735
Grand Total	218	£ 15,259,124

High Value Claims

Cause	Value	Nr Claims
Fail/Delay Admitting To Hosp.	£6,600,000.00	1
Fail / Delay Treatment	£4,299,222.09	2
Fail To Follow-Up Arrangements	£2,820,000.00	1
Failure/Delay Diagnosis	£1,475,000.00	1
Grand Total	£15,194,222.09	5



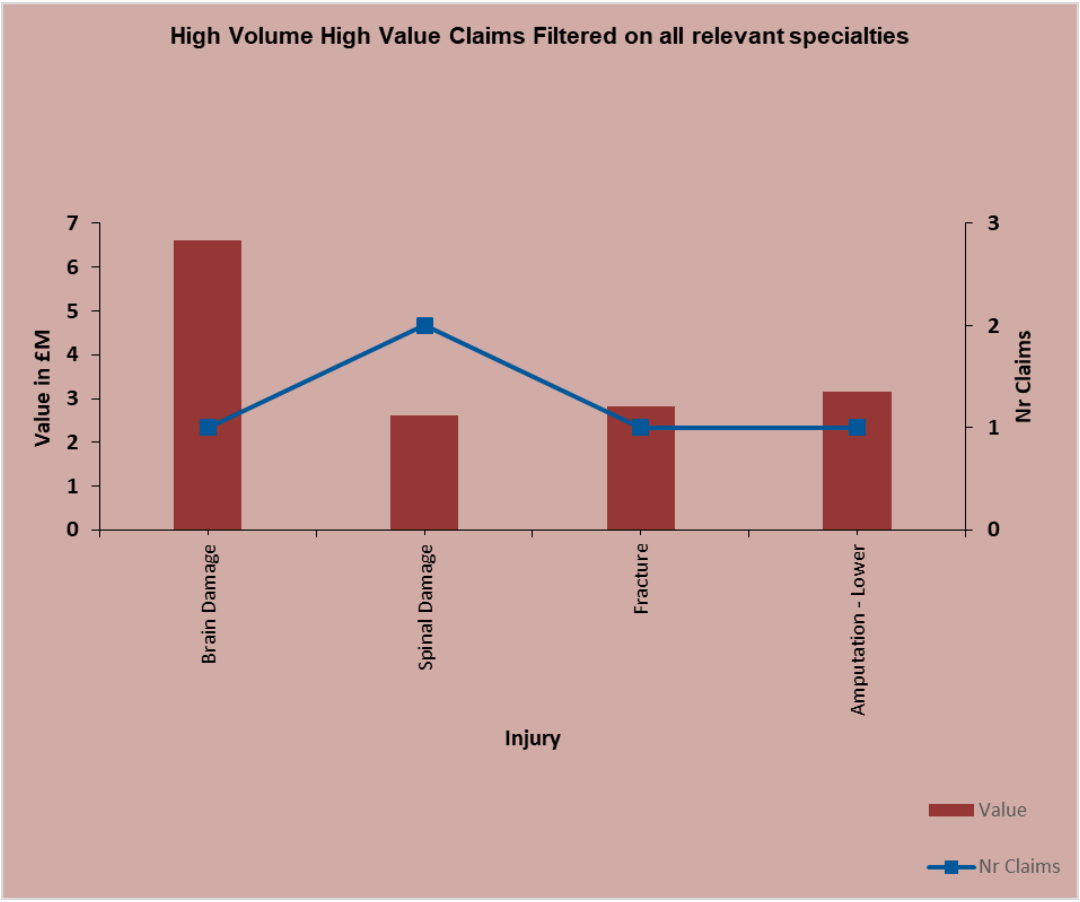
Selection criteria: CNST claims received with an Incident Date between 01/04/2010 and 31/03/2020

Total number of claims for DCH: 242

Total value of claims for DCH £35,311,841

Data correct as at: 31/08/2020

Injury	Value	Nr Claims
Brain Damage	£6,600,000.00	1
Spinal Damage	£2,615,000.00	2
Fracture	£2,820,000.00	1
Amputation - Lower	£3,159,222.09	1
Grand Total	£15,194,222.09	5



Selection criteria: CNST claims received with an Incident Date between 01/04/2010 and 31/03/2020

Total number of claims for DCH: 242

Total value of claims for DCH £35,311,841

Data correct as at: 31/08/2020

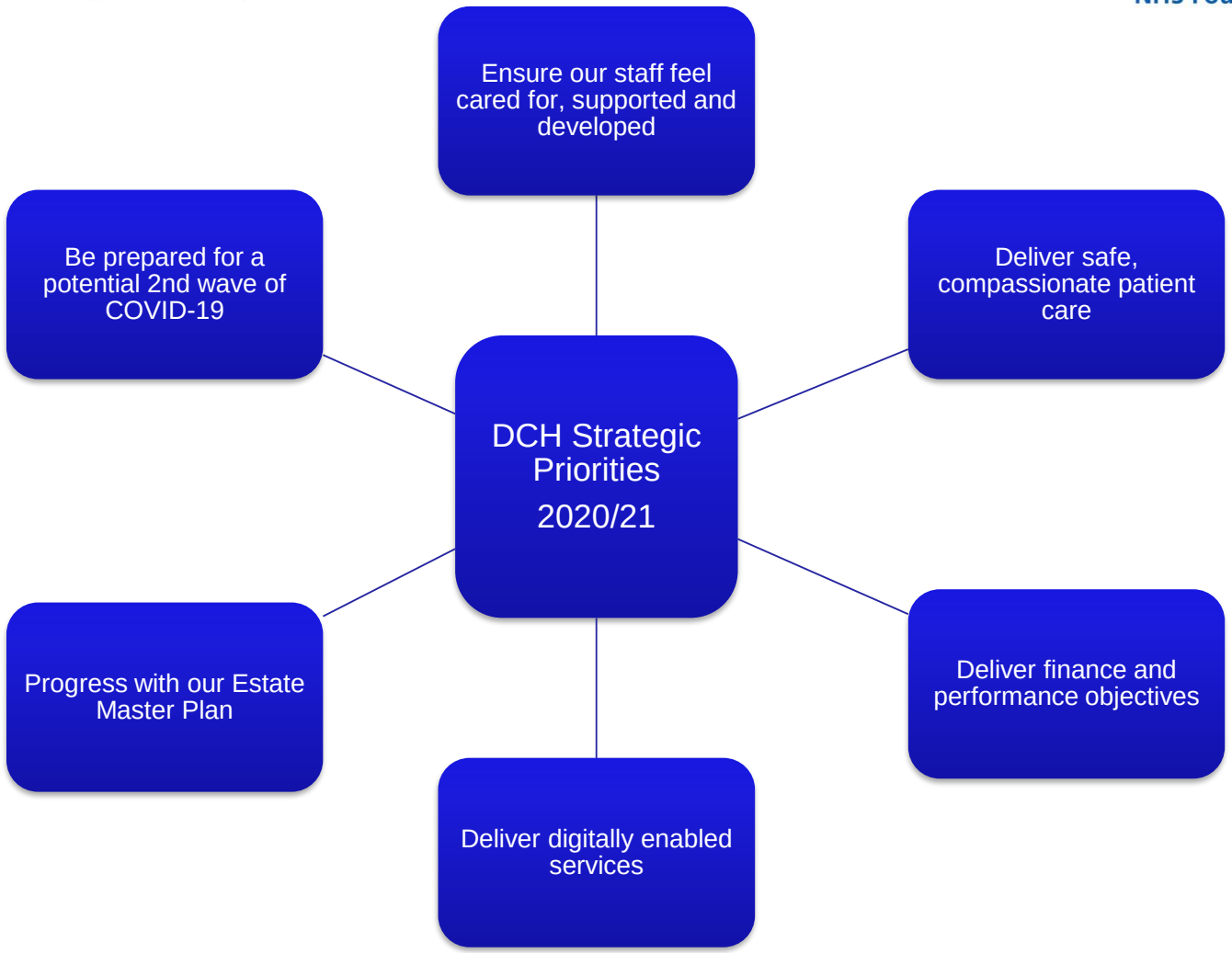
INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

DCH Strategic Priorities

2020/21

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
- Promoting equality and celebrating diversity
- Engage with our staff; share learning, experience and support positive change
- Ensure there is adequate access to personal protective equipment (PPE)
- Deliver seasonal flu vaccination programmes and ensure access to COVID-19 testing

Ensure our staff feel cared for, supported and developed

- Adhere to national IPC guidance and minimise hospital cross infections
- Engage with our public for quality improvement and service changes
- Ensure patients are seen in clinical priority by the right person, in the right environment, with minimal visits to the hospital

Deliver safe, compassionate patient care

- Deliver 20/21 financial control total
- 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 ethnic minorities

Deliver finance and performance objectives

- 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
- Work with the council to accelerate the plans for the multi-storey car park
- Move forward our plans for the Integrated Emergency, Community and Primary Care Hub

Progress with our Estate Master Plan

- Have our surge plans in reserve to implement and flex resources if and when required
- Develop a local Winter Plan, taking learning from our COVID experiences
- Use our available digital tools to act as an early warning signal

Be prepared for a potential 2nd wave of COVID-19

Outstanding care for people in ways which matter to them

Title of Meeting	**Council of Governors**
Date of Meeting	**9 November 2020**
Report Title	**Governor Vacancies**
Author	**Trevor Hughes, Head of Corporate Governance**
Responsible Officer	**Mark Addison, Chairman**

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

To gain the Council of Governors' approval to carry the vacancies in East Dorset, South Somerset and the Staff Constituency until the elections due in 2021 for terms commencing 10 July 2021.

Summary

Following the completion of the 2020 Governor elections, the Council of Governors currently has the following vacancies:

- East Dorset – one vacancy. Two seats were available in this constituency in the 2020 election but only one nomination was received.
- South Somerset and Rest of England – one vacancy. No nominations were received for this seat in the 2020 election.
- Staff Governors – two vacancies. Four seats were available in this constituency in the 2020 election but only two nominations were received.

The Trust's Constitution states:

Where the vacancy arises amongst the elected Members, the Council of Governors shall be at liberty either:

- To call an election within three months to fill the seat for the remainder of that term of office, or

- To invite the next highest polling candidate for that seat at the most recent election, who is willing to take office to fill the seat for any unexpired period of the term of office, or

- To carry one or more vacancies (such number to be agreed by the Council of Governors) until the next set of elections due, so long as this is not detrimental to the conduct of Council business.

<u>Considerations</u>

As no other nominations were received, it is not possible for the Council to invite the next highest polling candidate for that seat at the most recent election to take the seat.

If the Council of Governors were to opt for an additional election, they should be mindful that the cost to the Trust for the elections during 2020 was in the region of £5,500 not including the time factor for Trust staff.

The next round of Governor elections are due to be held in early summer 2021 therefore it is

recommended that the Council of Governors agree to carry the vacancies in East Dorset, South Somerset and the Staff Constituency until the elections due in 2021 for terms commencing 10 July 2021.
Risk Evaluation The Council of Governors needs to assure itself that the carrying of these vacancies is not detrimental to the conduct of Council business.
Impact on Care Quality Commission Registration and/or Clinical Quality N/A.
Governance Implications (legal, clinical, equality and diversity or other): Governance requirement under the Trust's Constitution for the election of governors.
Financial Implications There would be a financial implication in the current financial year if additional elections were to take place in 2020/21.

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

Recommendation	That the Council of Governors agree to carry the vacancies in East Dorset, South Somerset and the Staff Constituency until the elections due in 2021 for terms commencing 10 July 2021.