Ref: MA/TH
Date: 17th June 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 **24th June 2020 at 10.30am** at the Children's Centre Seminar Room 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
Committee Chair

AGENDA

1.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	10.30-10.35
	a) Apologies For Absence:	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 27th May 2020.	ENC 1	Mark Addison	Approval	
	d) Matters Arising: Action Log	ENC 2	Mark Addison	Approval	
2.	**Chief Executive's Overview**	ENC 3	Nick Johnson	Note	10.35-10.45
3.	**Integrated Performance Report including Committee Chair Input and Escalation Items** • **Quality** • **Performance** • **Finance** • **Workforce**	ENC 4	Nicky Lucey / Judy Gillow Inese Robotham / Stephen Tilton Paul Goddard / Stephen Tilton Mark Warner / Victoria Hodges	Note	10.45-11.05
4.	**COVID-19 Update** • **Overview Response Report**	ENC 5	Inese Robotham	Note	11.05-11.15
5.	**Restart, Redesign and Reset**	ENC 6	Nick Johnson	Discuss	11.15-11.35
6.	**Board Review and Messaging**	Verbal	Mark Addison	Approval	11.35-11.45

	CONSENT SECTION				11.45-11.50
	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.				
7.	**Mortality Report Q4**	ENC 7	Alastair Hutchison	Approve	
8.	**Any Other Business**				
	None Notified				
9.	**Date and Time of Next Meeting**				
	The next Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **10.30am** on the **29th July 2020** via Lifesize.				

ENC 1

Minutes of a Meeting of the Board of Directors of Dorset County NHS Foundation Trust Held at 10.30am on 27th May 2020 via Lifesize.

Present:		
Mark Addison	MA	Non-Executive Director *(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
Alastair Hutchison	AH	Medical Director
Nick Johnson	NJ	Acting Chief Executive
Nicky Lucey	NL	Director of Nursing and Quality
Ian Metcalfe	IM	Non-Executive Director
Inese Robotham	IR	Chief Operating Officer
Matthew Rose	MR	Non-Executive Director
David Underwood	DU	Non-Executive Director
Mark Warner	MW	Director of Organisational Development (OD) and Workforce
In Attendance:		
Simon Bishop	SB	Governor
Sarah Carney	SC	Governor
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships ***(item BoD20/073)***
Gavin Maxwell	MW	Governor

BoD20/066	**FORMALITIES**	**Action**
	The Chair declared the meeting open and quorate. Apologies for absence were received from Patricia Miller and Stephen Slough. MA summarised that arrangements were in train to support exiting of phase 1 of the COVID-19 pandemic and recognised the excellent work of the Executive team and colleagues throughout the hospital. He acknowledged that phase 2 presented more complex challenges as services were cautiously restarting and proposed that the focus of the meeting should be surrounding items 5, 6, and 7 of the Agenda. He noted important items within the Consent section including the Annual Report and Audited Accounts and that the Risk and Audit Committee, having delegated authority from the Board, had approved these. Best wishes were extended to NJ on behalf of the Board on the occasion of his birthday.	
BoD20/067	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the Agenda.	

BoD20/068	**Minutes of the Meeting held on the 29th April 2020**	
	There were no questions or points of accuracy raised in respect to the summary account of the meeting held on 29th April 2020.	
	Resolved: that the summary of the meeting held on the 29th April 2020 be approved as an accurate record.	
BoD20/069	**Matters Arising: Action Log**	
	No matters arising were raised in connection with the Action Log and the Committee agreed to close items completed. All items were identified within the agenda or paused due to the pandemic. It was agreed that the Staff Experience Feedback Video would be circulated after the meeting.	
	Resolved: that the Action Log be received and approval be given for the removal of completed actions.	
BoD20/070	**Chief Executive's Overview**	
	NJ recognised the hard work of colleagues as they continued to manage the Level 4 pandemic incident and in their preparations for managing the way forward. He advised that there was a focus on establishing antibody testing across Dorset. In response to the increased focus on BAME communities, NJ reported that the Board had circulated further information to members of staff in this group in order to provide support and that the BAME network was helping to promote risk assessment. He also noted the significant success in recruiting patients to the recovery trial and the work of the Research team in achieving this. DCH had continued to deliver urgent and cancer care and some elective and outpatient activity. Emergency Department (ED) attendances had increased to almost pre-COVID levels. Bed occupancy had also increased to circa 80%. NJ advised that staff wellbeing and compassionate care were key pillars of the planned clinically led management approach adopted in the implementation of social distancing measures and that the trust continued to work with system partners to ensure a consistent approach to resuming elective and non-clinical work whilst maintaining the ability to respond to the pandemic. Discussion of the same had taken place at the System Partnership Board meeting held on 6th May 2020 where representatives from across Dorset had focussed key tangible priorities. NJ highlighted that the number of eligible DCH staff who had received Influenza vaccinations was the highest across the system with 89% of eligible staff having been vaccinated. SA congratulated staff on their achievements in managing the	

	COVID-19 incident, the level of recruitment to the recovery trial, staff vaccinations and completion of the Annual Report and Audited Accounts. SA remarked that primary support for BAME staff appeared to be from line managers and questioned additional alternative routes by which this staff group could raise their concerns. MW advised that letters had been sent individually to each member of BAME staff advising them how to access further support including the Freedom to Speak Up Guardian role (FTSU). A virtual meeting had also been established in order to address any concerns raised and had been supported by an online system of raising concerns. He advised that colleagues were currently seeking assurances that risk assessments had been completed and that appropriate actions to protect staff had been taken. SA asked whether the system capacity and focus should be directed to supporting patient flows in and out of hospital given the reduced capacity resulting from the implementation of social distancing measures. IR advised that the current system focus was on care homes and the provision of suitable alternative accommodation to support hospital discharges and addressing mental health issues. Discussion was on-going regarding the increasing bed occupancy rate and about partner support measures to reduce admission to hospital. AH stressed the need to strengthen the role of Public Health across Dorset and this was supported by SA who commented on the need to refocus the public health message. JG enquired whether PPE was a limiting factor in resuming elective surgical activity. NJ advised that PPE availability would continue to be a limiting factor. IR advised that the Incident Management Team continued to monitor the situation in order to ensure that the trust could deliver both emergency and elective activity. She noted that it was anticipated that PPE deliveries would increase in accordance with increased activity levels.	
	Resolved: that the Chief Executive's Overview be received and noted.	
BoD20/071	**Integrated Performance Report**	
	Quality NL highlighted key areas of the report; noting previous discussion at Quality Committee of the Infection Prevention and Control (IPC) Assurance Framework and the impact of the bed occupancy rate on patient flow. Teams were heavily involved in this area of work and were looking at all available use of space options to maximise clinical capacity. National discussion was being had regarding social distancing measures and the use of Perspex.	

	AH updated on discussion of the Mortality index (SHMI) which was showing significant improvement in expected death rates as a result of improved coding. He advised that a review of excess deaths in non COVID-19 patients using a Structured Judgement Reviews (SJR) approach was commencing and would include case note reviews in order to identify any healthcare contributory factors. **Performance** IR highlighted the different approach to performance management over recent months due to the significantly changed operational environment and COVID-19 focus. She noted that A&E performance indicators remained consistently above 90% whilst retaining appropriate zoning within the department and the increasing demands for isolation and testing of elective patients. During May, emergency activity levels had increased to pre-pandemic levels. Referral to Treatment (RTT) compliance had reduced and composition of the waiting list had changed as a result of pausing elective activity and the impact of patient choice and a reduction in the number of referrals received. IR reported that Diagnostic activity had been stopped and some services had not yet recommenced such as Audiology; these two areas being of greatest concern. The standard for cancer treatment had achieved 93% during February and March 2020. **Finance** In April 2020 the NHS financial regime changed with a fixed income level matching cost base. DCH remained within £94k of the cost base and the 'true up' process allowed the trust to claim this and COVID-19 related expenditure from the government. Payment was anticipated in June. The ambition of the financial regime was to ensure the NHS achieved a breakeven position. The cash balance was circa £21m and had been centrally funded in order to ensure adequate cash flow. Agency expenditure had reduced from the March position from £1.3m to £0.8m due to reduced bed occupancy levels at that time. Expenditure was expected to increase during May due to increased bed occupancy rates. **Workforce** MW highlighted that most indicators had been impacted by the COVID-19 incident and reported that the workforce had increased by 65 FTE as students commenced working for the trust ahead of schedule on fixed term contracts. Workforce costs had also increased due to the pay increase effective from April 2020. The reduction in Agency spend and an analysis of the month 12 position had been reported to the Finance and Performance Committee the previous week and had noted the positive work to	

	actively manage agency expenditure through the sourcing of alternative and cheaper suppliers. The trust's current inability to recruit international nurses, as they were unable to leave their countries of origin, had the potential to impact future agency expenditure although discussion about resuming recruitment for clinical roles had started. Month 12 sickness absence showed a peak but remained consistent with the level in previous years when COVID related absence had been removed. Appraisal levels had increased. MW advised that a simple survey had been launched to better understand staff morale and wellbeing; the results of which would be reported to the next meeting and the on-going work to risk assess workspaces and implement social distancing in the workplace. Consideration would need to be given to the resulting estates impact and the use of office space in the longer term. VH raised the issues at Weston General Hospital as a consequence of the recent influx and enquired of system wide measures to manage Emergency Department activity. IR responded that summer peak activity had been planned and further planning for potential future waves in the pandemic was in train. NL reported that she had been in discussion with Weston General Hospital who had noted an early indicator of the potential problem had been an increase in staff absence. Asymptomatic staff and patients had been tested and were found to be COVID positive. The DCH Incident Management Team (IMT) had taken the learning and testing focussed on staff who are absent. She further advised that there was not a high incidence of patient discharged subsequently being found to be positive. Patients were tested on admission, again at seven days and it was planned to test again at 14 days also.	
	Resolved: that the Integrated Performance Report be received and noted.	
BoD02/072	**COVID-19 Update – Overview Response Report**	
	IR highlighted that NHS remained at incident management Level 4 and the Emergency Planning and Resilience Response (EPRR) arrangements needed to remain in place. The IMT remained operational every day and twice daily meetings continued. Site reconfiguration to accommodate segregation requirements had been completed, particularly within the ED and ICU and the air flow system in theatres. No constraints had been encountered regarding mortuary capacity and additional Nutwell Units were available providing an additional 40 spaces should these be required. IR expressed confidence in the trust's capacity and ability to respond	

	should there be a second wave. MA thanked IR for the report. SA enquired as to the availability of ICU staff and equipment in the event that a further wave in the pandemic materialised. IR advised that all ventilators and ICU equipment were being nationally procured and released on a local needs basis but that staffing would likely be sub-optimal. NL added that additional training had been provided for staff to increase the respiratory and ventilator care skill base and reminded that the discussion represented a worst case scenario and that lockdown measures would be re-introduced in the event of a second or subsequent pandemic spikes.	
	Resolved: that the COVID-19 Update be received and noted.	
BoD20/073	**Phase 2 Framework**	
	Paul Lewis joined the meeting for this item NJ outlined key points of the framework as the country was moving away from phase 1; the immediate response, into phase 2 which had increased complexity and ambiguity. He noted that the immediate response needed to be maintained whilst moving to a tactical and strategic response in the medium term over the coming 18-24 months. NJ explained that the slides set out the framework but that the strategic approach was emergent as learning continued and a large number of variables would impact delivery, direction and pace. The framework provided some guidance as to the operating framework going forward and NJ explained that the process would need to remain iterative and dynamic. A clear set of objectives and tests would be kept under review by the Executive team in conjunction with the senior management team. MR asked about the constraints on the delivery of next phase objectives and site reconfiguration. SA commented positively on the document and the considerations within it and asked how the strategic intentions could be progressed both in terms of the site and the sustainability agenda. She expressed some concerns about the number of task groups in existence given the principal of 'keeping things simple'. JG supported this, noting that the level of current engagement, particularly medical engagement, had been positive, and stressed that this should not be lost and opportunities for learning and development should be capitalised. Whilst MA commented positively on the briefing paper, he sought clarity on the degree of resonance amongst staff of the Restart, Redesign and Reset model amongst the wider staff contingent; suggesting	

	greater clarity might be required. VH proposed that a single purpose provided a strong focus and simple message and that this was required in order to resonate with staff. NJ acknowledged the need to maintain simplicity, particularly when constraints introduced complexity and added that organisational development had been included as a key objective AH reiterated the need for a simple message and outlined the potential for plans to be impacted by a second pandemic wave and reintroduction of financial constraints at some future point. He noted that clinical engagement and leadership had been very useful with clinicians actively engaging with the Executive team through the use of digital technology and he acknowledged that this should make future planning easier. NL acknowledged the level clinical engagement and the extent and pace of change still required across the system, noting the shared learning in order to deliver in a timely manner. Task and finish groups were aware of their function. Key learning had been around system working and enabling regional rather than local working arrangements and decision making over recent months. MA summarised the uncertain times and the need for a map going forward; emphasising simplicity of objectives and effective communications going forward. NJ reiterated that the document was iterative and regular updates would be provided to the Board with key communications and decisions being progressed through committees. Further consideration would be given to the forward work programme. Paul Lewis left the meeting.	**NJ**
	Resolved: that the Phase 2 Framework be approved.	
BoD20/074	**Restart Process**	
	IR explained that activity had been heavily regulated throughout the crisis and that a cautious restart of elective activity had commenced whilst maintaining IPC measures. A number of positive solutions had been successfully implemented and there was a strong desire to continue the operation of these. It was anticipated that the contract for use of the independent sector hospital would be extended until September in order to continue provision of urgent and cancer care services and the addition of some routine activity and End Of Life care should the need arise. Other providers were also being considered for the provision of some services i.e. orthopaedic and endoscopy services and the activity and costing were comparable to previous DCH casework.	

	Elective activity was resuming within the national requirement for patients to isolate for 14 days with family members and be swabbed 72 before admission. Initial patient feedback had expressed difficulty in achieving this requirement for some patients. Activity was being maximised although it had not yet been possible to determine future capacity. SA questioned whether the household isolation requirement difficulties had been escalated nationally. NL stated that the national guidance remained unchanged due to the increased potential risk to successful outcomes if it was not followed.	
	Resolved: that the Restart Process be noted.	
BoD20/075	**COVID Response Phase 1 Learning and Understanding**	
	PG commented that the slide deck was self-explanatory and thanked the Research and Transformation teams for their work in collating the data. Key themes and findings were outlined within the report and it was hoped that the paper could be further developed and published. The paper has been presented for information and the ambition was to engage with patients at a future point. The findings would be integral to the further development of the Restart programme.	
	Resolved: that COVID Response Phase 1 Learning and Understanding be received and noted.	
BoD20/076	**Board Committee Governance**	
	MA directed discussion to the four recommendations. NL urged that the divisions did not yet have capacity to present their reports to committee and proposed that this element of committee agendas remained paused at this time. This was widely supported by the Executive team. JG sought assurance regarding divisional and care group governance arrangements and the proposal to continue the divisional pause was agreed but would be kept under review. The remaining elements of the governance framework were agreed.	
	Resolved: that the Board Committee Governance arrangements be approved.	
BoD20/077	**Strategic Priority Items**	
	No further points were raised in connection with this item.	
BoD20/078	**Infection Prevention and Control Assurance Framework**	
	NL advised that the framework had been discussed in detail by Quality Committee the previous week. Some gaps in assurance had been noted and mitigating actions identified. NL asked to note that the results of COVID testing undertaken outside the NHS were known to the Department of Health and Social Care and the issue	

	of these results being notified to the NHS was being taken forward by national teams. NL noted that the IPC Assurance Framework provided an assurance tool for the Board and that it was not a regulatory measure. MA thanked the team for collating the report.	
	Resolved: that the Infection Prevention and Control Assurance Framework be noted.	
Bod20/079	**Items Requiring Board Approval**	
	• **Letter of Representation** This was approved • **Annual Board Declarations** TH outlined the documents and statutory requirements surrounding the declarations. PG explained the rationale for signing the Continuity of Service 3b declaration outlining uncertainty surrounding future financial sustainability given the changed financial regime and national COVID funding arrangements. The declarations were approved.	
	Resolved: that the Letter of representation be approved and signed on behalf of the Board by the Acting Chief Executive and the Chair. **Further resolved: that the Annual Board Declarations be approved, signed on behalf of the Board by the Acting Chief Executive and published on the Trust Website.**	
BoD20/080	**Messaging**	
	MA recognised the step by step approach being adopted for the forthcoming challenging period and the commissioned research to capture staff experiences in real time and requested that NJ and colleagues convey the Board's gratitude for the hard work and huge achievements during phase 1 of the pandemic. JG urged the need for simplicity in staff communications and stressed the value of continued leadership communications of the trust's approach going forward. GM commented on the impact of uncertainty on future plans. MA remarked on the need to establish a sense of direction. MA acknowledged MR's contribution to the Board and the Trust over the preceding six years and that this would be MR's last Board attendance; thanking him for his wisdom and offered best wishes for the future. The sentiment was echoed by Board members.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	

BoD20/081	**Annual Report and Audited Accounts**	
	IM briefly recapped the process for preparation of the Audited Accounts and Annual Report; reporting that the trust continued to operate as a going concern and that an unqualified audit opinion had been received. The Audit and Risk Committee had approved the report and accounts and recommended these to the Board. The Head of Internal Audit Opinion had provided moderate assurance on the Trust's systems on internal control the risk related to COVID 19 recently added to the Corporate Risk Register had been considered in detail.	
BoD20/082	**Committee Minutes**	
	The following Board Committee Minutes were received: **a) Finance and Performance Committee** April 2020 **b) Quality Committee** April 2020 c) **Workforce Committee** April 2020 d) **Audit and Risk Committee** March 2020	
BoD20/083	**Annual Guardian Report of Safe Working Report**	
BoD20/084	**Any Other Business**	
BoD20/085	**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 **24th June 2020** at **10.30** via Lifesize. A Board Development session will take place following the meeting	

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Signed by Chair …….. Date ……..

Action Log – Board of Directors.

Presented on: 24th June 2020

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated: 27th May 2020						
BoD20/073	**Phase 2 Framework**	Further consideration to be given to the forward plan to ensure simplicity of objectives and staff communications	**NJ**	**June 2020**	Further discussion to be had at the Board Development session in June.	Yes
Meeting Dated: 25th March 2020						
BoD20/046	**-**	The Board to come back to the staff survey results after the COVID-19 pandemic.	**TH**	**Post-COVID**	**Paused due to COVID-19**	
Part One Actions from Previous Meetings						
BoD20/001	**-**	The Director of OD and Workforce to check with the education team what basic life support training was available Board members.	**MW**	**March 2020**	**Paused due to COVID-19**	
BoD20/006	**-**	Report front sheets to be updated to include risk appetite statement and social values.	**PM/TH**	**April 2020**	**Paused due to COVID-19**	
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 work plans and agreed objectives from Finance and Performance Committee, Quality Committee and Risk and Audit Committee to be brought to the March Board of Directors meeting.	**TH - MR, JG, IM**	**March 2020**	**Paused due to COVID-19**	
BoD20/008	**-**	The Wessex Deanery had made it	**PM/MW**	**March**	**Paused due to**	

		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.		**2020**	**COVID-19**	
BoD20/008	**-**	ICS Performance Report: clarification required regarding the risk perception evaluation relating to Prevention at Scale and clarification required on where this work feeds in to.	**NJ**	**March 2020**	**Paused due to COVID-19**	
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**	**Paused due to COVID-19**	
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**	**Paused due to COVID-19**	
Actions from Committees…(Include Date)						

Board Strategic Work Programme Items Suspended due to COVID-19

Meeting	Items from Work Plan
April 2020	• Social Value • Quality Improvement • Equality and Diversity • Wellbeing • Sustainability
May 2020	• Estates Strategy
June 2020	• Nil

Enc

Title of Meeting	**Board of Directors**
Date of Meeting	**24 June 2020**
Report Title	**Chief Executive's Report**
Author	**Nick Johnson, Acting Chief Executive**
Responsible Executive	**Chief Executive**

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

Summary

DCH staff at all levels continue to demonstrate their outstanding commitment to the hospital and meeting the needs of our patients during an evolving yet increasingly challenging period for the hospital. As the first 'wave' of covid reduces and other activity continues to increase, the hospital faces increasing constraints in the delivery of services.

The number of covid positive patients has remained in single figures over the past month and for a small number of days there were no confirmed covid positive patients in the hospital. The number of staff absent with symptoms has also dropped to single figures. An early warning system has been established to identify any signs of a likely second surge.

Activity at the hospital continues to increase. Major ED attendances have returned to pre-covid levels and non-elective admissions continue to increase. Elective activity continues to gradually increase as the clinicians cautiously and carefully establish new ways of working to minimise the covid risk. Bed occupancy for the month has been around 80% and discharges have begun to slow down.

Increasing constraints are emerging which will affect the hospital's capacity and productivity. These include the requirement for segregation of suspected covid patients and non-covid patients, social distancing requirements which reduces the number of beds available, the requirement for testing routine patients 14 days prior to a procedure, increased use of PPE which reduces the number of patients who can be allocated to an operating list, and reduced availability of consumables.

Work is ongoing to secure additional capacity for the hospital and to ensure that clinical risk is managed robustly.

The hospital continues to manage the covid incident as a Level 4 incident, as required nationally, and has also established a process to manage the ongoing restart, redesign and reset of the hospital over the short, medium and long-term. A more detailed update on the hospitals ongoing response to covid and the resolution of key challenges is provided in the subsequent Board papers.

Staff safety and well-being continues to be the number one priority for the hospital – with compassionate and safe care, capacity and communication being the other identified priorities for the period. A staff well-being survey was undertaken in May to help our understanding of how staff are feeling and how we can continue to support them in as many ways as possible. In total 264 responses were received, which is just under 8% of staff. Responses were overall positive in terms of how staff felt the hospital had supported them through the period however, there was useful and honest feedback about what more we could do to support staff.

Ongoing national announcements affecting the NHS and the hospitals operations are increasingly being made without consultation, with no prior warning and no accompanying guidance which

creates implementation issues for staff. However, the teams have responded well to these difficult circumstances.

The Black Lives Matters movement has brought into stark focus the issues created by systemic racism which leads to significant inequalities for BAME communities. In addition Public Health England released a report considering the disparities of outcomes in different groups which found that BAME people were 10-50% more likely to be affected by covid than white people.

The hospital, via its BAME network is considering what more it must do to ensure that it supports and stands by all BAME staff and that we create a culture of belonging and inclusion for everyone. Enhanced risk assessments are available to BAME staff and BAME staff have been prioritised for antibody testing. There is more the hospital can and must do to support all of our BAME colleagues and address the systemic inequalities which exist in the UK and in the NHS.

DCH continues to be part of the international RECOVERY trial which is trialling novel treatments for covid-19 and was part of the trial which led to the announcement that dexamethasone should be recognised as a potential treatment for covid patients receiving respiratory support.

A number of national or regulatory requirements which were suspended during the first phase of the covid pandemic (e.g. complaints procedures) are beginning to be reviewed and the hospital will re-instigate these according to the national guidance.

National NHS Planning Guidance covering the period from August to March 2021 is due to be issued imminently. It is expected that System based submissions – consisting of organisational plans – will be required by July 13th.

The Dorset Integrated Care System Partnership Board met on the 18th June and reviewed the proposed revised ICS Vision, Mission and Priorities for the Dorset ICS moving forward.

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 place 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.	
Financial Implications Failure to address key strategic and operational risks will place the Trust at risk.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

CEO Report – National Perspective

June 2020

PHE – Disparities in the risk and outcomes of COVID-19

Public Health England (PHE) has published their report on the disparities in the risk and outcomes of COVID-19. The inequalities identified in the report largely replicate existing inequalities in mortality rates in previous years, with the exception of BAME groups; mortality was higher in white ethnic groups in previous years.

As yet there has been no full publication of the recommendations for action that will need to follow in order to address these inequalities.

Following the release of this report the Government's Equality Hub set out their next steps including;

- Review effectiveness and impact of current actions being undertaken by relevant Government departments and their agencies to directly lessen disparities in infection and death rates of COVID-19.
- Modifying existing or develop new policy.
- Commission further data, research and analytical work by the Equality Hub to clarify the scale, and drivers, of the gaps in evidence highlighted by the report.
- Consider where and how the collection and quality of data into the disparities highlighted can be improved on and take necessary action.
- Lead engagement on the disparities highlighted with Departmental Ministers.
- Build on and expand stakeholder engagement undertaken by PHE to consolidate and develop the qualitative insights gained and how they may support further actions that should be taken to address the disparities highlighted.
- Strengthen and improve public health communications to ensure they reach all communities across the country.
- Provide quarterly updates to the Prime Minister and Secretary of State for Health and Social Care on progress being made to address health inequalities by departments and their agencies.

The NHS Race and Health Observatory

The NHS Confederation and NHS England have created a new centre to investigate the impact of race and ethnicity on people's health; identifying and tackling the specific health challenges facing people from BAME backgrounds. The Observatory will involve experts both nationally and internationally, offering analysis and policy recommendations to improve outcomes for NHS patients, communities and staff.

Test and Trace

To help stop the spread of COVID-19 the Government has launched the Test and Trace service to ensure that anyone who develops symptoms of COVID-19 can be tested to establish if they have the virus. For those tests proven to be positive, close recent contacts can be identified and contacted to notify them of the requirement to self-isolate at home.

The service also includes targeted asymptomatic testing of NHS and social care staff as well as care home residents.

NHS Trusts are asked to roll out plans for asymptomatic testing on a regular basis in line with the Operating Framework for Urgent and Planned Services in Hospital Settings during COVID-19.

Antibody Testing

NHS and care home staff have been prioritised to receive the antibody tests for COVID-19, the test will not mean those receiving a positive result are immune or they cannot pass the virus on, social distancing measures must continue to be adhered to. There will be value in knowing if these groups of staff have had the virus and in collecting data on test results.

Clinicians will be able to request an antibody test for patients in both hospital and social care settings if deemed appropriate.

Visiting Arrangements

NHS Visiting Guidance has been updated, lifting the national suspension on visiting; it is now subject to local discretion by Trusts and other NHS bodies. It provides advice on how NHS organisations may choose to facilitate visiting across healthcare inpatient settings.

Surgical Masks Requirements

There is some evidence using surgical face masks can reduce the transmission of COVID-19, the World Health Organisation suggests extended use of facemasks should be considered when the risk is higher including for those working in close contact with the public. Hospitals have been asked to ensure visitors and outpatients to hospital settings wear a mask as well as hospital staff in both clinical and non-clinical areas that are not robustly COVID-19 secure.

Mental Health and Wellbeing

May saw the National Mental Health Awareness Week, this is more important than ever as we all have a responsibility to be mindful of the toll a pandemic and a pandemic response can have on the NHS workforce and the wider health implications for the nation.

Trusts need to be mindful of the impact on their workforce, recognise they will need time to rest and recover, being cautious in their restart.

The Centre of Mental Health forecasts at least half a million more people in the UK may experience mental ill health as a result of the pandemic and associated socio-economic impacts of lockdown such as unemployment, housing issues and social isolation. With this in mind key requirements for mental health will need to be considered by the Government

including PPE and testing, prioritisation and demand and capacity planning, funding and workforce.

Blueprint for Return

As lockdown restrictions are gradually easing and Trusts look at restarting those services stepped down during the peak of the pandemic NHS Trade Unions published their Blueprint for Return which outlines nine key requirements including, sufficient PPE, risk assessment requirements, access to testing and rapid results, extending current COVID-19 pay arrangements, proper work/life balance, safe staffing levels utilising the Bring Back Staff initiative, wellbeing support, childcare and recognition of contribution during COVID-19 in future conversations relating to pay.

Care Quality Commission (CQC) – The Emergency Support Framework (ESF)

Whilst routine inspections have been halted the CQC has launched The Emergency Support Framework (ESF). The framework is not an inspection and is not a rating of performance.

There are a number of elements to the framework which include using and sharing information to target support where it is needed most, having open and honest conversations, taking action to keep people safe and to protect people's human rights and capturing and sharing what we do.

The framework will be used in all health and social settings registered with the CQC during and for a period after the pandemic.

RECOVERY Trail in COVID-19 – Dexamethasone

Results of the Dexamethasone arm of the International RECOVERY trail in COVID-19 have demonstrated the use of Dexamethasone has clear mortality advantages in patients with COVID-19.

The trail has illustrated Dexamethasone reduces deaths by one-third in ventilated patients and one fifth in other patients receiving oxygen however for those patients who did not require respiratory support there was no benefit.

Due to the clear mortality advantage through using a well-known medicine it has been deemed reasonable for practice to change in advance of the full paper from the trail. Clinicians are therefore being asked to consider Dexamethasone for the management of hospitalised patients with COVID-19 who required oxygen or ventilation.

There are no current or anticipated constraints on the supply of Dexamethasone in the UK.

Balanced-Score Card Performance Report

Report to Board: 24 June 2020

Performance Summary:

The Trust achieved the four hour Emergency Access Standard (EAS) in May 2020 with performance of 95.4% (combined with MIU). Performance of Type 1 activity was 92.8% which was an improvement on the 89.4% achieved in April 2020. The department continues to run segregated areas for COVID-19 suspected and non COVID-19 suspected patients and is utilising the footprint of Surgical Admissions Lounge as a discharge area from the department. An order has been placed for a modular build to increase the triage footprint; expected delivery date is July 2020. Following the recent national guidance all emergency admissions are swabbed for COVID-19 on admission and then re-swabbed at seven days length of stay. ED activity continues to track below historical monthly averages; there were 3,254 attendances in May 2020 compared to 4,238 in May 2019. This was an increase of 1,039 compared to April 2020 and equally admissions increased by 358 compared to previous month. Interestingly ambulance arrivals were consistent with May 2019 – there were 1,303 arrivals by ambulance in May 2020 compared to 1,300 in May 2020. The RTT constitutional standard was not achieved and the performance deteriorated further – 46.42% versus 52.55% in April 2020. Whilst the total waiting list reduced further by 269 patients, the backlog of patients waiting over 18 weeks from referral to treatment increased by 743 and there were 456 patients waiting over 52 weeks at the end of April 2020 which is reflective of the national suspension of routine elective activity due to COVID-19. The trust continues to increase utilisation of private sector capacity made available at BMI Winterbourne and elective admissions (including day cases) at the Winterbourne increased by 165.96%in May 2020 compared to April 2020. Also an additional 35 Orthopaedic patients have been transferred as an inter-provider transfer in May. Patient uptake of offers of dates for routine surgery remains low due to the nationally mandated requirement for patients and their households to self-isolate for 14 days prior to elective surgery. The Trust's performance against the 62 day cancer standard currently stands at 72.6% and will not be finalised until the first week of July. Total 62 day cancer PTL stands at 622 compared to 614 as at the end of April 2020, however, the number of patients waiting over 62 days has increased from 96 to 194. This significant increase is due to patients choosing to delay treatment or where the clinician responsible for patient's care has deemed that an extended waiting time presents less risk to the patient's outcome than the risk of catching COVID-19. All tumour sites continue to regularly review and risk stratifying patients on the PTL. The Trust achieved the 2 week wait standard for both breast symptomatic and all cancers in May 2020 - 93.5% and 95.5% respectively. The referral numbers remain lower than historical averages but there was a lesser impact of patient choice with a higher uptake of appointments offered. Performance against the 6 week diagnostic standard remained on par with April 2020 – 40.85% versus 40.89% and reflects the impact of suspension of routine diagnostic tests due to COVID-19 nationally. A large proportion of the over 6 week backlog is in Audiology and sleep studies where routine activity remains suspended. Endoscopy and imaging have re-commenced limited routine activity and insourcing arrangements have been put in place for additional endoscopic activity and commenced on the last weekend of May 2020.

Main Performance Risks facing the Trust in 2020/21

Quality and Access risks:

- Whilst the current ED attendances remain below historic levels of activity and the COVID-19 activity in South West is below national levels, there is a significant risk of a future surge of either COVID or non-COVID emergency activity (or both simultaneously).
- Public behaviours, in particular, reluctance to access acute services poses a risk of deterioration of existing conditions in the population and potential presentation of more complex cohorts of patients in the future.
- Growing waiting times on RTT and diagnostic waiting lists pose clinical risk to patients despite clinical prioritisation and mitigation measures in place
- The need to segregate COVID and non-COVID clinical activity in all care settings for the foreseeable future has significant efficiency and resource implications.

Financial risks:
In response to COVID-19 the national finance regime has been amended with effect from 1 April 2020, initially until 31 July 2020, but now we understand until at least 31 October 2020. These changes include:

- Suspension of National Tariff Payment System (PbR), Trusts to be paid block amounts
- Business Planning suspended and Trusts given a plan for the first four months of the year (this is now likely to be extended to October at the earliest as noted above)
- Payments for additional costs relating to COVID – 19
- A “True Up” payment for Trusts to maintain a breakeven position
- System wide Capital spend targets

As a response the Trust has reported a £50k deficit position for May 2020, after including a “True Up” payment assumed from NHS England of £0.842 million. This amount is to cover the additional costs of the Trust’s COVID19 response (£0.862 million) in the month and a residual balance of income over expenditure (£0.02 million). Receipt of this funding will only be confirmed in mid-July 2020. The cash balance at 31 May 2020 was £25 million as a result of the Trust receiving May’s block payments in advance in April.

Workforce Committee Escalations 15.6.20

- Staff Wellbeing Pulse Check Survey – a recent survey returned a mixed range of responses from staff who commented positively on the level of colleague support, advances in IT developments and daily communications. The ever changing PPE guidance, the pace of change and a degree of feeling isolated due to home working had been challenging for staff. A new policy on home working is in development to support staff in this area.
- A wealth of action and learning opportunities arose from the survey and would be kept under review by the committee.
- The impact of COVID-19 on Black, Asian and Minority Ethnic staff is an area of focus for the committee and the need for this staff to complete an appropriate risk assessment is being re-emphasised.

Quality Committee Escalations 16.6.20

- Demand had increased during the month and bed occupancy had increased to circa 80%. The implementation of social distancing measures and zoning in clinical and ward areas is also impacting capacity.
- There had been a significant improvement in the SHMI over the previous ten moth period.
- Friends and Family Test data in out-patients had not been submitted due to COVID-19 priorities but would be made available.
- The increasing Waiting List remains an area of concern for the committee.
- Issues surrounding changing PPE guidance and the impact of bed movements were causing some staff anxiety.
- Seven-day working arrangements had been implemented although weekend working arrangements and senior leadership capacity presented challenges.
- Visitors are now able to return to the hospital in a limited manner. A consistent approach to visiting arrangements has been adopted across Dorset.
- **Recommend** the Catering Strategy to the Board

Finance and Performance Committee Escalations 16.2.20

- An Extraordinary meeting of the Finance and Performance Committee was held on 9.6.20 and approved the tender award proposal to replace two theatre air handling units
- Emergency Department performance has met the 95% waiting time standard.
- Concerns around demand and capacity was noted along with planned further discussion at the Board of Director meeting at the end of June.
- As a result of the changed national funding regime, further work to clarify the trust's underlying position is to be completed.
- Whilst there has been a slight reduction in the overall waiting list position due to increased short term activity and reduced numbers of referrals, the proportion of those patients waiting over 18 weeks has increased.

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

Safe

- The Pan-Dorset Quality Surveillance Group (QSG) took place virtually on 21st May 2020; Dorset County Hospital remains on 'Routine Surveillance'.
- There have been no Never events reported during this period.
- There were no falls resulting in severe harm during this reporting period.

Effective

- The staffing return has been ceased and it has not been included in the report.

Caring

- The recommendation rates for the friends and family test have achieved the standard required for Maternity, ED and Inpatient areas.
- There has been a slight deterioration in the recommendation rates for the Friends and Family Test in Outpatients.

Responsive

In May 2020 the following standards were met:

- Emergency Access Standard (combined with MIU)
- Total RTT waiting list size
- 2 week wait breast symptomatic from urgent GP referral to first appointment
- 2 week wait all cancers from urgent GP referral to first appointment
- All Cancers – 31 Day Subsequent Treatment (Anti-Cancer Drugs)
- All Cancers - 31 day Subsequent Treatment (Surgery)
- All Cancers - 31 day Subsequent Treatment (Radiotherapy/Other)

Standards not met:

- RTT
  - Prioritisation of elective waiting list has been undertaken in line with national guidance
  - Specialty level plans in development for gradual restart of activity
  - Utilisation of Independent Sector capacity at BMI Winterbourne
  - Significant interdependencies with PPE and consumable availability
  - Self-isolation and swabbing requirements prior to surgery will significantly impact patient readiness and willingness to proceed with elective surgery
- All Cancers – 62 day referral to treatment following an urgent GP referral
  - Prioritisation of the cancer PTL has been undertaken in line with national guidance and continuous clinical reviews in place
  - Significant increase in backlog due to patient choice to delay treatment or a clinical decision to delay treatment following a risk assessment
  - Weekly tracking meeting taking place chaired by COO
  - RCA process in place for patients with a confirmed diagnosis of cancer who have waited over 104 days for treatment
- All Cancers – 31 Day Diagnosis to First Treatment
  - Patient choice to delay treatment in a small number of cases
- Diagnostic 6 week wait
  - Deterioration against the standard due to suspension of routine diagnostic activity
  - New CT scanner has been delivered and is operational
  - Additional endoscopic capacity has been insourced and commenced at the end of May 2020

Well Led

Total workforce capacity (substantive plus bank) increased by 9 FTE in Month 02 and was 260 FTE above prior year; this small was primarily in substantive workforce numbers which increased by 12 FTE. Total workforce costs (substantive, bank and agency combined) reduced by £4k in Month 02 however this was the net effect of a significant increase in substantive and bank workforce costs and a reduction in agency staffing costs of £219k. Total agency staff costs were £586k in May 2020, of which £239k was attributed to the COVID-19 response. The agency spend less the COVID-19 related costs were £140k below M02 costs in 2019/20.

The sickness absence rate for Month 01 (April) decreased by 0.9% to 4.91%. With COVID-19 related sickness absence excluded, the figure was 3.50% which was a slight increase on M12.

The annual appraisal rate (i.e. the percentage of the substantive workforce having received a performance appraisal within the previous 12 months) decreased by 7% to 75%, which reflect the formal pausing of annual appraisals. The appraisal process is currently under review and will be discussed at the August Workforce Committee meeting.

Metric	Threshold/ Standard	Type of Standard	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Movement on Previous Period	12 Month Trend
Safe											
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	Contractual (National Quality Requirement) 2019/20	1 (0.1)	**2 (0.2)**	0 (0.0)	**2 (0.3)**	0 (0.0)	0 (0.0)	0 (0.0)	↔	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	**94.5%**	95.3%	**94.1%**	**94.4%**	N/A	N/A	N/A	↑	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	0	3	1	0	1	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	1	**2**	**2**	**2**	**2**	**4**	**6**	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.2)	2 (0.2)	3 (0.3)	↓	
Emergency caesarean section rate			17.6%	23.1%	12.2%	16.2%	14.5%	15.0%	14.8%	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	97.3%	91.4%	96.2%	**76.9%**	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	92.3%	96.4%	100%	100%	N/A	N/A	N/A	↔	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**84.4%**	**82.1%**	95.0%	**88.9%**	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	100%	100%	100%	100%	N/A	N/A	N/A	↔	
Effective											
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	**1**	**1**	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**<1.12 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	**1.16**	**1.15**	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**117.3**	**116.8**	**115.3**	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**116.8**	**115.4**	**114.8**	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	B	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency	**90%**	Contractual (Local Quality Requirement)	**20.9%**	**34.0%**	**43.5%**	**44.1%**	**31.8%**	**31.7%**	**31.7%**	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive	**90%**	Contractual (Local Quality Requirement)	**50.0%**	**85.7%**	**50.0%**	**78.6%**	**57.1%**	**84.6%**	**70.4%**	↑	
Caring											
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	25	34	39	24	10	N/A	10	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	N/A	N/A	N/A	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	98.4%	98.5%	97.7%	97.1%	100.0%	100.0%	100.0%	↔	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	88.4%	**83.4%**	86.9%	91.4%	93.1%	90.4%	91.6%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	95.2%	94.5%	94.4%	**93.8%**	**91.9%**	**91.2%**	**91.5%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**21**	**16**	**14**	**10**	**11**	N/A	**11**	↑	

Metric	Threshold/ Standard	Type of Standard	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Movement on Previous Period	12 Month Trend
Responsive											
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month'	**92%**	Contractual (National Operational Standard)	**67.0%**	**66.6%**	**65.6%**	**60.7%**	**52.6%**	**46.4%**	**46.4%**	↓	
RTT Incomplete Pathway Waiting List size	**11,991**		**16,228**	**15,699**	**15,791**	**15,190**	**14,479**	**14,210**	**14,210**	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**87.7%**	**82.0%**	**87.6%**	**89.0%**	**81.9%**	95.5%	**88.9%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**84.2%**	100.0%	93.5%	95.3%	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	97.7%	98.3%	97.6%	**95.0%**	97.5%	**91.7%**	**94.5%**	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**90.9%**	**88.9%**	100.0%	**92.3%**	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	**96.3%**	100.0%	**94.7%**	100.0%	**96.6%**	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	100.0%	100.0%	-	100.0%	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	88.8%	**64.0%**	86.1%	90.5%	**69.4%**	**72.6%**	**71.1%**	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**70.0%**	**63.6%**	**16.7%**	100.0%	**64.7%**	**33.3%**	**60.0%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**97.3%**	**97.6%**	**96.0%**	**84.4%**	**40.9%**	**40.9%**	**40.9%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**82.4%**	**81.0%**	**85.9%**	**88.7%**	**89.4%**	**92.8%**	**91.4%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from	**95%**	Contractual (National Operational Standard)	**91.4%**	**90.6%**	**93.2%**	**94.1%**	**93.2%**	95.4%	**94.5%**	↑	
Well Led											
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**4.12%**	**4.45%**	**3.76%**	**5.81%**	**4.91%**	N/A	**4.9%**	↑	
Appraisal rate	**90%**	Internal Standard reported to FPC	**86%**	**86%**	**83%**	**77%**	**82%**	**75%**	**79%**	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	10.1%	10.1%	10.3%	10.1%	9.4%	9.4%	9.4%	↔	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,487.1	2,493.06	2,520.8	2571,40	2,620.5	2,632.5	2,626.5	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	8.0%	7.7%	9.2%	7.8%	7.6%	6.4%	7.0%	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**9,609.3**	**9,955.6**	**9,725.3**	**10,035.6**	**10,537.1**	**10,658.3**	10,597.7	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	1	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**89%**	**89%**	**89%**	90%	88%	87%	88%	↓	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,129**	**2,453**	**1,973**	**2,244**	**476**	**971**	**1,447**	↑	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,026,752**	**£2,277,318**	**£2,147,020**	**£2,269,226**	**£453,697**	**£998,053**	**£1,451,750**	↑	
Surplus/(deficit) (year to date)	**2020/21 = Breakeven YTD M1 = Breakeven**	Local Plan	(3,164)	(2,316)	(1,652)	205	0	0	0	**N/A**	**N/A**
Cash Balance	**2020/21 - 1,784 M2 = 4,007**		12,744	13,132	14,020	7,335	21,269	N/A	N/A	↑	
CIP - year to date (aggressive cost reduction plans)	**2020/21 = N/A under current plan YTD M1 = N/A**	Local Plan	4,111	4,608	**5,085**	**5,710**	N/A	N/A	N/A	**N/A**	**N/A**
Agency spend YTD	**2020/21 = No Annual value YTD M2 = 1328**		**5,046**	**5,743**	**6,499**	**7,837**	**806**	**1,393**	**1,393**	**N/A**	**N/A**
Agency % of pay expenditure	**2020/21 = No Annual value YTD M2 = 5.9%**		**5.7%**	**5.4%**	**5.5%**	**7.8%**	**6.7%**	5.8%	5.8%	↑	

Movement Key

Favourable Movement ↑
Adverse Movement ↓
No Movement ↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Apr-20	May-20
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	**50% reduction by 2021**	0 (0.0)	0 (0.0)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	0 (0.0)	0 (0.0)
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	0	3
	SHMI - Rolling 12 months, 5 months in arrears (Jan-19 to Dec-19)	**<1.12**	**1.15**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Feb-19 to Jan-20)	**100**	**115.3**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**52.6%**	**46.4%**
	RTT Incomplete Pathway Waiting List size	**11,991**	**14,479**	**14,210**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**69.4%**	**72.6%**
	Maximum 6 week wait for diagnostic tests	**99%**	**40.9%**	**40.9%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**93.2%**	95.4%
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**453,697**	**998,053**
	Surplus/(deficit) (year to date)	**2020/21 = Breakeven YTD M1 = Breakeven**	0	0
	CIP - year to date (aggressive cost reduction plans)	**2020/21 = N/A under current plan YTD M1 = N/A**	N/A	N/A
	Agency spend YTD	**2020/21 = No Annual value YTD M2 = 1328**	**806**	**1,393**

Rating Key

Title of Meeting	**Trust Board**
Date of Meeting	**24 June 2020**
Report Title	**COVID 19 – Overview Response Report**
Author	Inese Robotham, Chief Operating Officer
Responsible Executive	Inese Robotham, Chief Operating Officer

Purpose of Report (e.g. for decision, information) For NOTING
Summary NHS has been in Level 4 Incident due to COVID-19 pandemic since 03 March 2020. In response DCH has put in place an Incident Management Team and has developed plans to scale up Emergency Department, Critical Care, Ward and Mortuary capacity to deal with increased numbers of COVID-19 positive patients. These plans are reviewed and amended on regular basis to respond in fluctuation of COVID-19 and non COVID-19 activity.
Paper Previously Reviewed By N/A
Strategic Impact The mandated need to rapidly respond to the incident has resulted in displacement of routine activity and significant redesign will be required to restart routine appointments/surgery within the constraints of the need for social distancing and requirement to preserve scale up capacity in readiness for future surges of COVID-19.
Risk Evaluation The outlined arrangements provide capacity to deal with current COVID-19 activity and mitigation against future spikes during the pandemic.
Impact on Care Quality Commission Registration and/or Clinical Quality The outlined arrangements draw on best practice and latest infection control guidelines to ensure clinical quality of care for the patients and safety and reduced risk of exposure for both staff and patients.
Governance Implications (legal, clinical, equality and diversity or other): It is a legal requirement to have appropriate Emergency Planning Response and Resilience structures in place to enable the organization to effectively respond to and manage an incident
Financial Implications The NHS COVID-19 response is funded centrally; however, robust financial management remains paramount in order to withstand scrutiny and subsequent reimbursement of COVID-19 related expenditure.

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

Recommendations	To NOTE the update on Incident Management structure in place and current operational response to the COVID-19 Incident.

Title of Meeting	**Trust Board**
Date of Meeting	**24 June 2020**
Report Title	**COVID 19 – Overview Response Report**
Author	**Inese Robotham, Chief Operating Officer**

1 Introduction

NHS England and NHS Improvement declared the spread of COVID19 a **Level 4 incident** on 03 March 2020. This is the highest level of emergency and means that emergency response is coordinated at national level.

All NHS provider and commissioning organisations were mandated to implement a 24/7 incident management team structures at organisational and system levels to receive and act on national instructions and information requests.

Both the Dorset wide command and control structure and internal DCH Incident Management Team structure were presented at the previous Trust Board meeting and remain in place as per NHS England and NHS Improvement letter dated 29 April 2020 instructing that NHS organisations need to fully retain their Emergency Planning Response and Resilience (EPRR) incident coordination functions given the uncertainty and ongoing need. This paper provides an update on the Trust's EPRR response to date and plans to retain COVID 'surge' capacity should it be needed again.

2 Incident Management Structure and latest Situational Report

DCH Incident Management Team remains functional 24/7. IMT meetings are taking place on Mondays, Wednesdays and Fridays with a backup rota in place to increase frequency if required; out of hours the incident management is led by the on call teams with additional support from EPRR.

To date the highest peak in COVID-19 activity at DCH was on 06 April 2020 – twenty confirmed positive inpatients of which five were on Critical Care. Currently (as on 17 June 2020) there are no confirmed COVID-19 positive inpatients at DCH. The contingency arrangements remain in place and as per latest national guidance all emergency admissions are swabbed for COVID-19 and isolated where possible; a re-swab is then undertaken 5-7 days after admission. This adds complexity in patient pathways and in management of available cubicle and bed capacity.

DCH has had twenty seven confirmed COVID-19 positive patient deaths of which one was an NHS employee. The last confirmed COVD-19 positive death at DCH was recorded on 12 June 2020.

3 Site Reconfiguration

3.1 Emergency Department Footprint

DCH Emergency Department remains segregated into COVID and non-COVID areas. It continues to operate from an expanded footprint that includes what was previously Orthopaedic outpatients and Surgical Admissions Lounge. The anticipated delivery date for modular build to increase triage capacity is July 2020. The department has implemented a more flexible segregation plan to be able to increase the non-COVID assessment capacity whilst suspected COVID-19 activity remains low.

3.2 Critical Care Footprint

Similarly to ED, Critical Care has implemented segregation into COVID and non-COVID areas and is operating from an extended footprint which includes CCU and Maud Alexander Ward and additional six dialysis points have been installed in the unit. A reviewed escalation plan has been agreed with a reduced ventilation capacity. GREEN escalation capacity now equates to 8 ventilated beds (previously 21), AMBER goes up to 17 ventilated beds (previously 37) and RED to 25 ventilated beds (previously 57). Both AMBER and RED could be managed with existing staffing resources but would require additional critical care ventilators. RED escalation would also require the use of Day Case theatres for scaling up physical footprint. Estates works have been completed within the Theatre footprint and patient pathways have been tested in practice. The reduction in capacity is mainly related to discounting the use of anaesthetic machines for mechanical ventilation which were included in the original escalation plan. The latest research shows poorer outcomes for patients who have been ventilated using anaesthetic machines compared to patients on dedicated critical care ventilators. It has to be noted that even during the peak of the pandemic at DCH, there was no need to utilise anaesthetic machines as the highest number of COVID-19 patients in DCH critical care was five (as on 06 April 2020) and even then not all five patients required mechanical ventilation simultaneously.

3.3 Ward Capacity

Ward escalation plan for COVID-19 activity has not changed and Moreton ward remains designated as the receiving ward followed by Ilchester ward and Inpatient Emergency Care (IPEC). Further work is in progress to enhance infection control measures with particular focus on social distancing. A Task and Finish group is in place to identify both ward areas where the number of beds needs to be reduced and areas that could be converted back into clinical use to replace any lost bed capacity.

3.4 Mortuary Capacity

Baseline mortuary capacity equates to 74 spaces. At the peak of the pandemic an additional 18 space Nutwell Unit was put in place with the option of a second 18 space Nutwell and a four space dedicated bariatric Nutwell to be added if required. As this additional capacity was not required, from the beginning of May 2020 the Nutwell was removed and the mortuary is functioning at the baseline capacity. The option to scale up the Nutwells remains in place. Current mortuary usage is on average 10-15 spaces.

4 Personal Protective Equipment (PPE)

The levels of PPE stock are monitored through the Incident Management Team daily and any incidences of stocks running low are escalated through to the national process. To date DCH has not run out of any items of PPE and on a number of occasions has been able to provide mutual aid to the health economy partners. There have been incidences of irregular deliveries, reduced number of items ordered being delivered and variable make and quality of stock being delivered. In particular the variability of make of the protective masks has been a challenge as staff have had to be fit mask tested on a number of makes/models.

Equally the quality of both sterile and non-sterile gowns has been variable requiring local risk assessments of the usability of the gowns in different clinical settings.

The trust has implemented national mandate for all staff (both clinical and non-clinical) to wear surgical masks when transitioning through the hospital and in areas were social distancing is not possible and PPE would not be routinely mandated. Equally PPE has been made available for visitors to the hospital as per latest national guidance.

5 Recommendations

The Trust Board is asked to:

NOTE the update on Incident Management structure in place and current operational response to the COVID-19 Incident.

Enc

Title of Meeting	**Board of Directors**
Date of Meeting	**24 June 2020**
Report Title	**COVID19 Restart, Redesign & Reset Update**
Author	**Paul Lewis – Deputy Director Strategy, Transformation and Partnerships**
Responsible Executive	**Nick Johnson – Acting Chief Executive and Director of Strategy, Transformation and Partnerships**

Purpose of Report (e.g. for decision, information)
To provide a update on the Trust's progress to COVID19 Restart, Redesign & Reset

Summary

The Trust's response effort to COVID19 continues to be led through the Incident Management Team that meets three times a week with a backup rota to increase frequency if required. Capacity has been created in ED, Critical Care and wards in case of a surge in demand. Pleasingly, we had no COVID19 positive patients in hospital for a few days from Friday 12 June 20, the first time since the beginning of March 20. Critical Care and bed occupancy remains high and limits capacity to make wholesale changes quickly.

Our overarching objectives remain and continue to guide us; staff safety and wellbeing, compassionate and safe care to patients, the ability to escalate bed capacity in response to surges and good communications.

The Redesign & Reset (R&R) Senior Management Team (SMT) has been formed. The inaugural meeting was 27 May 20. This group meets weekly and is chaired by the CEO. The group ensures work undertaken maintains alignment with our principles. It provides leadership, guidance, prioritisation, decision-making and escalation functions.

To deliver the work effectively it has been split into nine task & finish (T&F) groups. These groups are time-limited and have clear objectives. Each T&F group is led by an Executive Director, management and project lead. The T&F groups are empowered to 'get on and do' and escalate by exception; typically when a significant decision is required, other areas will be affected or access to scarce resources is required. T&F group reporting is in place and kept light touch to maximise the delivery capacity.

The T&F groups are; Staff well-being, Staff Social Distancing, Staff Testing, Patient social distancing, Restart Cell, Outpatient cell, Service configuration and estate utilisation, Office and Admin Space (including flex working approach) and Learning & Innovation. The T&F group objectives are in the appendix.

The cross-cutting teams; Urgent and Integrated care, Family Services and Surgical, Workforce, Finance, Nursing and Quality, Digital and Estates provide updates on demand and escalate issues. To support them, priorities are made clear.

In the next month the R&R SMT will establish itself and develop rhythm and routine. The T&F groups will continue to progress at pace, constricted only by the operational demand.

Paper Previously Reviewed By
Chief Executive

Strategic Impact Supports delivery of the strategic outcomes	
Risk Evaluation Risk is managed within existing governance arrangements	
Impact on Care Quality Commission Registration and/or Clinical Quality Directly supports clinical quality improvement	
Governance Implications (legal, clinical, equality and diversity or other): Not applicable in this paper	
Financial Implications Costs to be managed within existing budgets or subject to separate business cases	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided

COVID19 Response Update

Restart, Redesign & Reset

Nick Johnson Acting Chief Executive Officer &
Director Strategy, Transformation & Partnerships

Overarching Objectives

- Staff Safety and Well-being
- Compassionate and safe care
- Capacity
- Communications

Covid-19 Phase Objectives

1. Ensure all urgent, cancer and time-critical procedures are being delivered
2. Review and prioritise waiting lists, reducing backlog and establishing appropriate processes and procedures to manage restart
3. Restart routine activity and other key work in a planned manner given new COVID19 constraints
4. Develop a clear rolling demand and capacity plan
5. Redesign the hospital – clinical models, infrastructure, support services etc - to benefit from key learning and innovation and to ensure the hospital can manage ongoing Covid/Non-covid activity and potential future waves/surges
6. Identify and understand key learning, quality improvements and innovation and seek to secure, expand and embed these into BAU

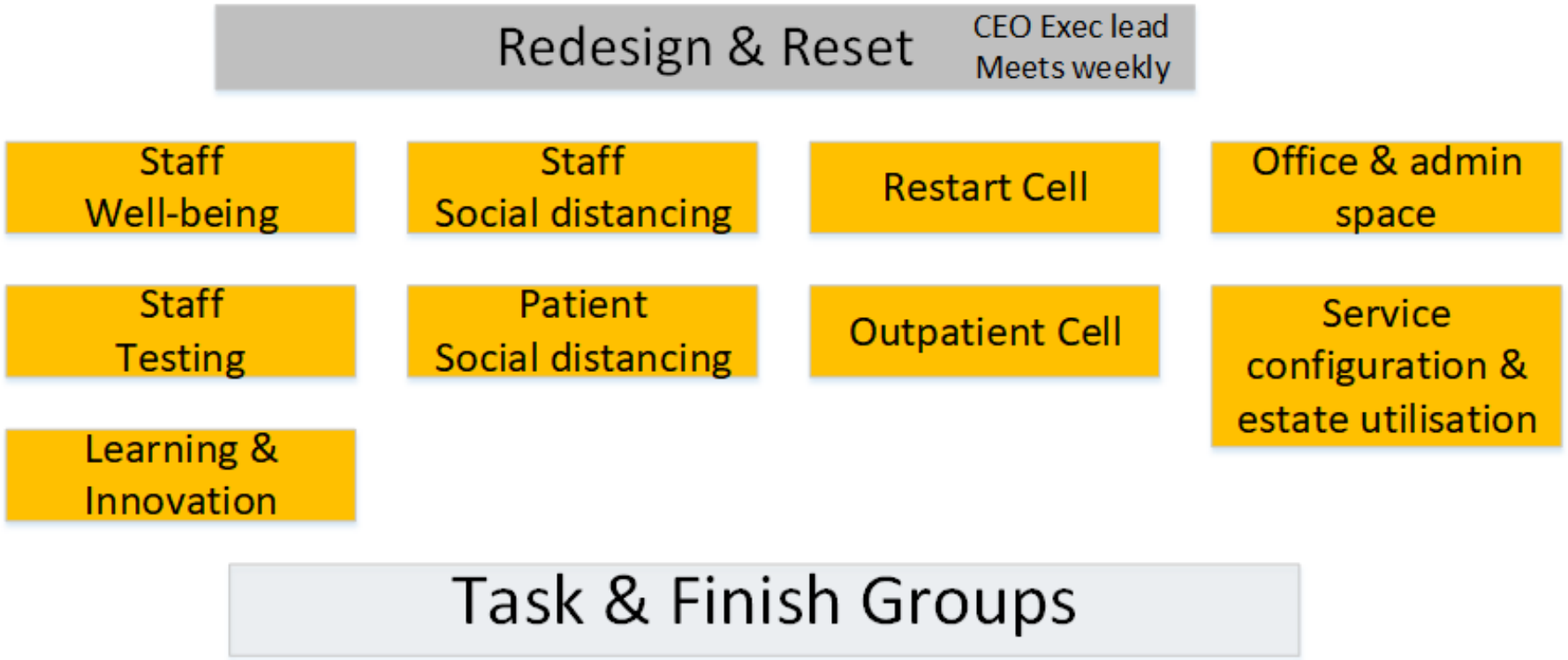
Headlines

- Response to the incident continues
  - We remain at level 4
  - IMT led by COO meets three times a week with a backup rota to increase frequency if required
- Hospital occupancy high – limits capacity to transform
- Redesign & Reset SMT formed

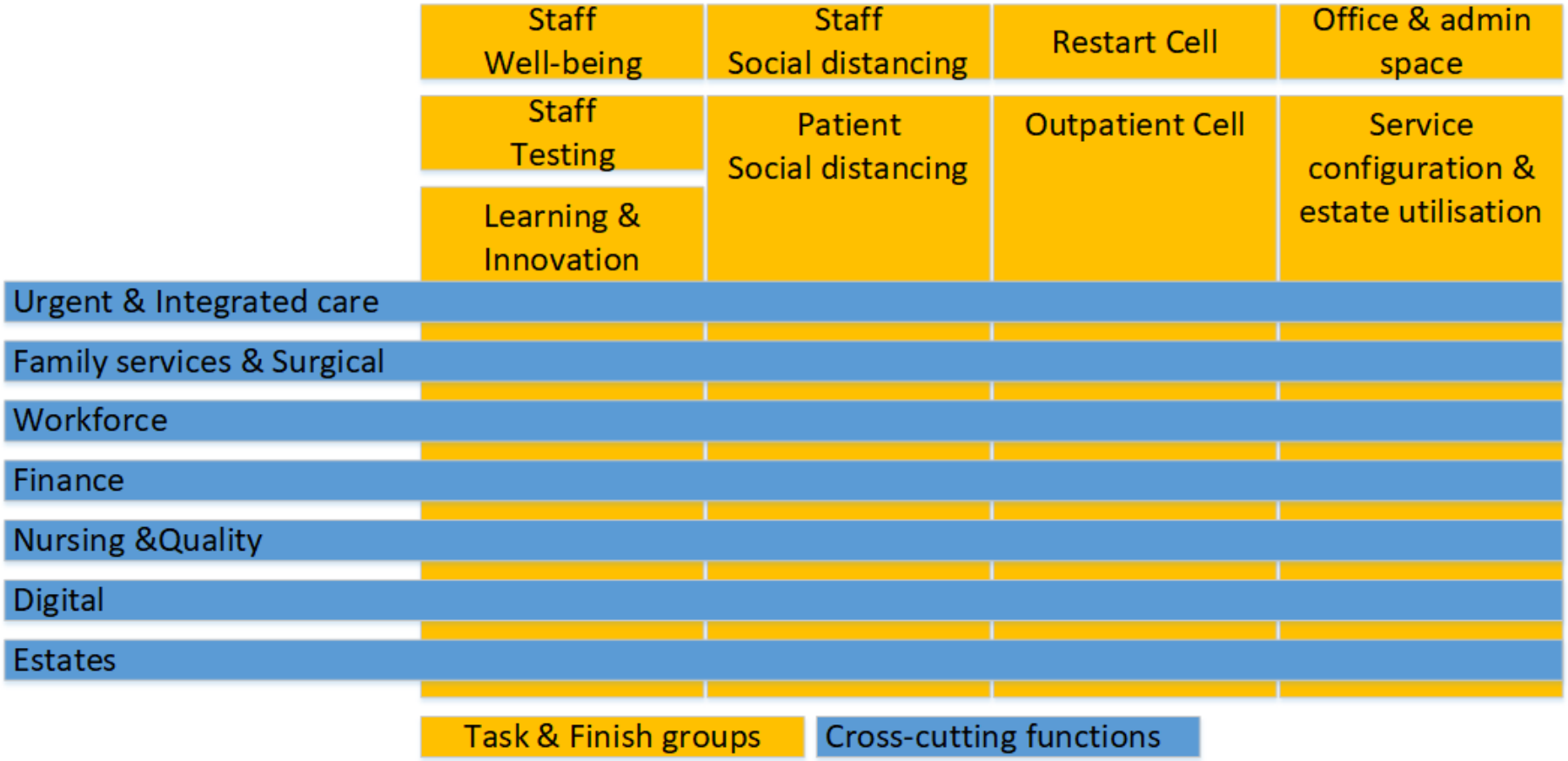
Redesign & Reset SMT

- Formed 27 May 20 and meets weekly
- Created 9 time-bound Task & Finish (T&F) groups
- Meeting provides leadership, guidance, prioritisation, decision-making and escalation functions.
- Reporting is light to maximise delivery effort
- T&F groups submit items for decision and escalation
- Key cross-cutting functions able to escalate too

Governance


Redesign & Reset
CEO Exec lead
Meets weekly
Staff Well-being
Staff Social distancing
Restart Cell
Office & admin space
Staff Testing
Patient Social distancing
Outpatient Cell
Service configuration & estate utilisation
Learning & Innovation
Task & Finish Groups

Task & Finish Groups & Cross-cutting Functions matrix



Key activity & issues

- Staff well-being and support - survey
- Increasing demand – ongoing flow and discharge
- Reducing capacity & productivity – demand and capacity modelling
- Social distancing – additional capacity sourcing
- Wait lists/times – clinical reviews
- Use of Independent sector – orthopaedic focus

Appendices

Task & Finish Group Objectives

T&F Group	Leads Exec/Mgmt/Project	Purpose/Objective
Staff well-being	Mark Warner, Bernadette Pritchard, Alice Burkmar	The provision, signposting and promotion of staff well-being services to keep our staff resilient
Staff Social Distancing	Mark Warner, Emma Hallett, Dave Hillier	To develop, implement and communicate the Trust's approach to social distancing in non-clinical areas to reduce of C19 transmission
Staff Testing	Mark Warner, Catherine Youers, Laura Limm	Provision, delivery and reporting of staff COVID19 testing to understand staff risk and immunity
Patient social distancing	Nicky Lucey, Anita Thomas, Lyndsey Bulley	To develop, implement and communicate the Trust's approach to social distancing for inpatient beds on all wards to reduce of C19 transmission
Restart Cell	Inese Robotham, Adam Savin, Toby Hood	The planning and provision of elective procedures to treat our patients
Outpatient cell	Inese Robotham, Catherine Abery-Williams, Toby Hood	Provision and delivery of outpatients making maximum use of telephone and virtual mediums to treat our patients
Service configuration and estate utilisation	Paul Goddard, Alastair Hutchison - *Clinical lead,* Andy Morris, Ben Print	Optimising service and estate configuration to optimise the delivery of clinical services
Office and Admin Space	Paul Goddard, Andy Morris, Ben Print	Provision, planning and implementation of new and existing work space to enable staff to work safely
Learning & Innovation	Paul Goddard, Zoe Sheppard, Paul Lewis	Observation, capture and sharing of learning and innovations to inform the other Task & Finish groups

Title of Meeting	**Board of Directors**
Date of Meeting	**24 June 2020**
Report Title	**Mortality Report: Learning from deaths Qtr 4 2019/20**
Author	Prof. Alastair Hutchison, Medical Director
Responsible Executive	Prof. Alastair Hutchison, Medical Director

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

Summary
The Trust's SHMI and HSMR figures remain elevated in the 'higher than expected' category. 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 to review the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses identified. This process has been strengthened by the introduction of Medical Examiners during Q2, who undertake a rapid review of the notes of every in-patient who dies whilst under the care of DCH staff.

Paper Previously Reviewed By
Quality Committee 16 May 2020 (and revised version 16 June 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 a higher than expected 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/HSMR can have a negative impact on the Trust's reputation both locally and nationally.

Risk Evaluation
- Clinical coding data quality is adversely affecting the Trust's ability to assess quality of care
- Reputational risk due higher than expected SHMI/HSMR
- Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement
- 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 higher than expected 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

Recommendations	The Board is asked to note the content of the report.

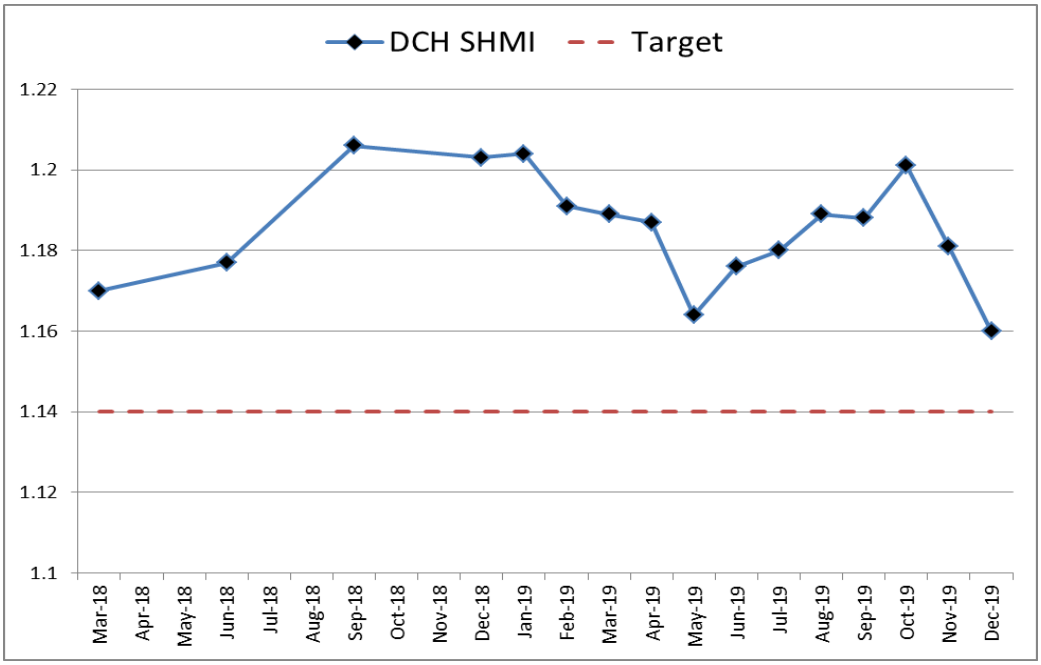
MORTALITY DATA AND STATISTICS

1.1 Data Summary – rolling year to December 2019

The HSMR is provided by DrFoster for a rolling 12 month period, and usually 4 months in arrears. SHMI is provided by NHS Digital for a 12 month rolling period, and usually 5 months in arrears. In summary:

- The HSMR remains statistically significantly higher than expected, at 117.5 (Dec 2019)
- Compared to 22 small and rural peers, the Trust is one of five with a statistically significantly higher than expected HSMR
- The SHMI for the rolling years to October, November and December 2019 remains statistically significantly higher than expected, but reducing to 116.0 (Dec 2019) which represents its lowest level for the past 20 months. Changes within the coding department came into effect in the month of October 2019.

1.2 Summary Hospital-level Mortality Indicator (SHMI)



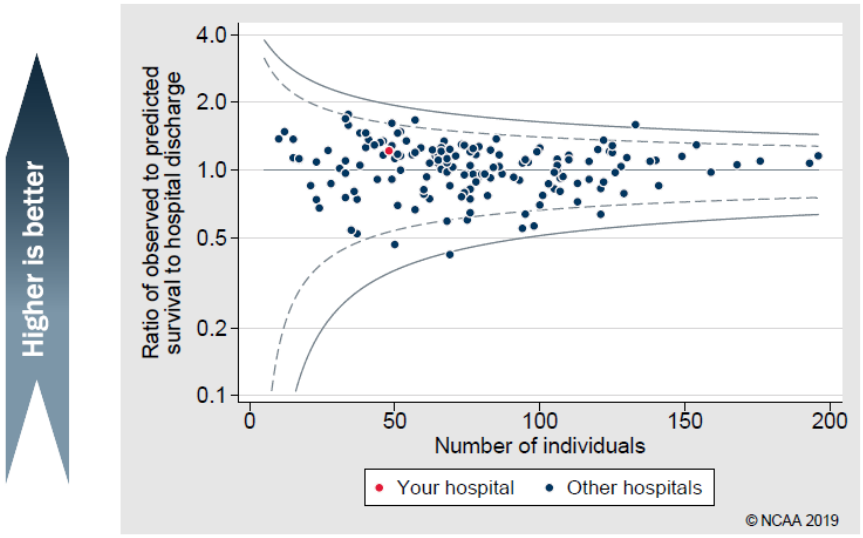
The target range for SHMI is shown above at around 1.14, but this varies according to overall national performance.

2.0 OTHER INDICATORS OF CARE

With SHMI and HSMR both higher than expected, the DCH Hospital Mortality Group regularly examines other data which might relate to standards of care, and has continued to meet on a monthly basis. The following sections report data available from various national bodies who report on individual Trusts' performance. For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, VTE, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing.

2.1 NCAA Cardiac Arrest data published June 2019

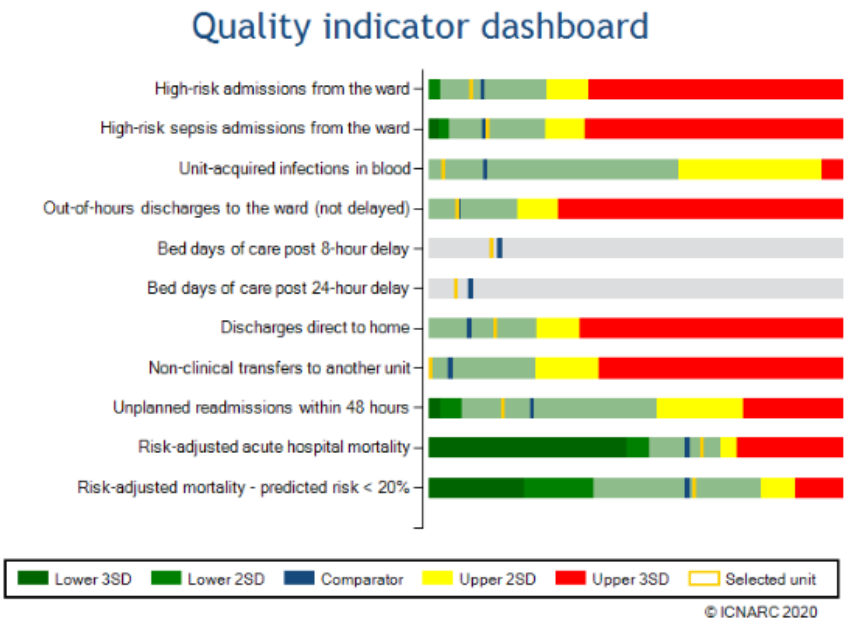
Funnel plot of observed to predicted survival to hospital discharge



2.2 Pneumonia mortality data published November 2019

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

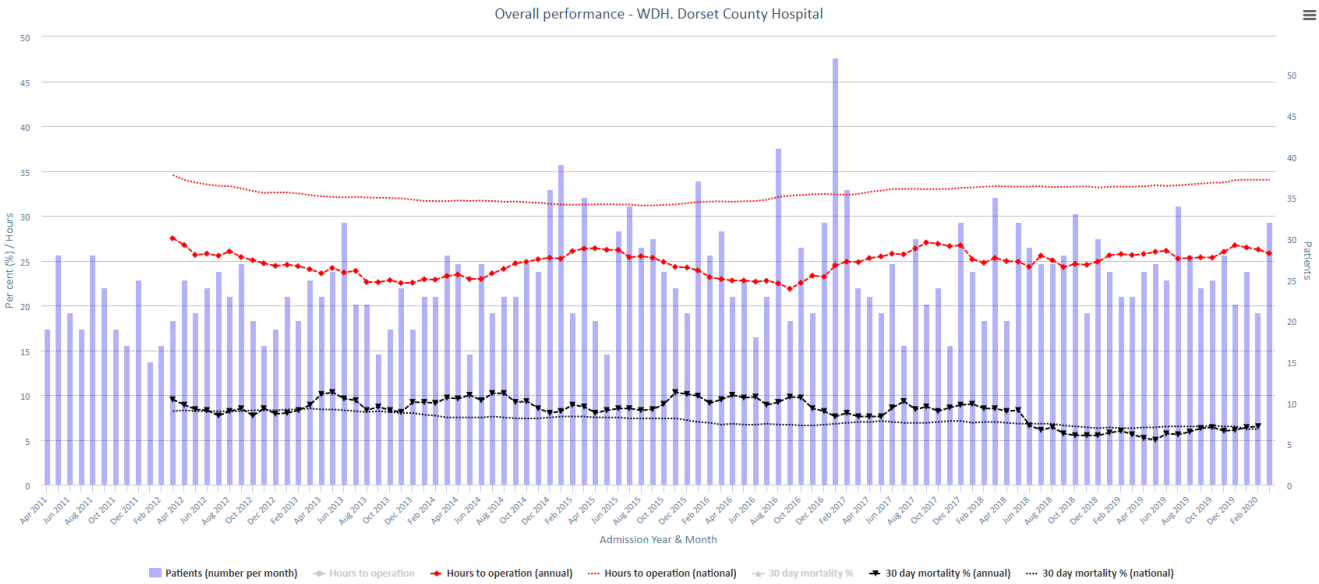
2.3 ICNARC Intensive Care survival data published 4/12/2019



- The Quality indicator dashboard shows the potential quality indicators (and their agreed thresholds)
- Individual potential quality indicators are also shown as funnel plots *(see: Results)*

Data shown are based on at least six months data for each unit; available data (by quarter) for each unit can be viewed via the *Active participation* graph.

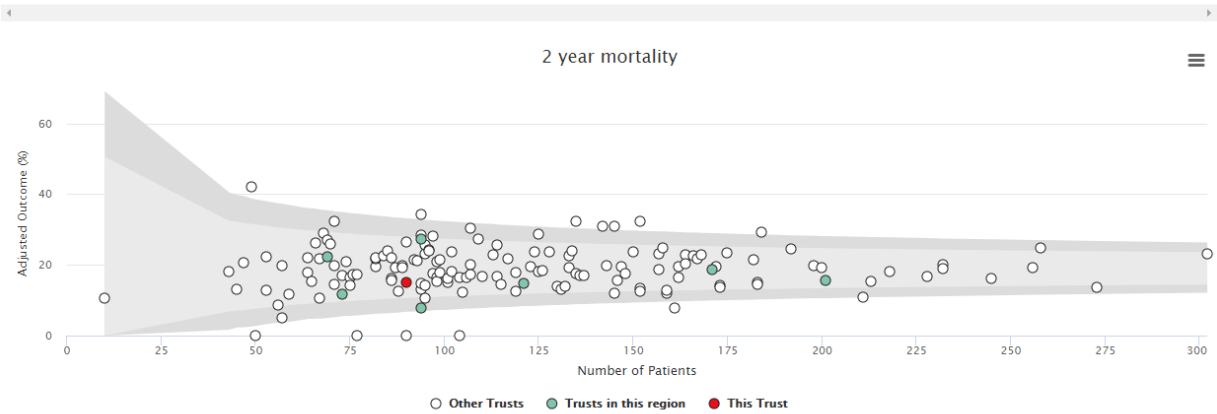
2.5 National Hip Fracture database to February 2020



Time from admission to operation remains significantly better than the national average, with 30 day mortality just above the national average at 6.5%.

2.6 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%

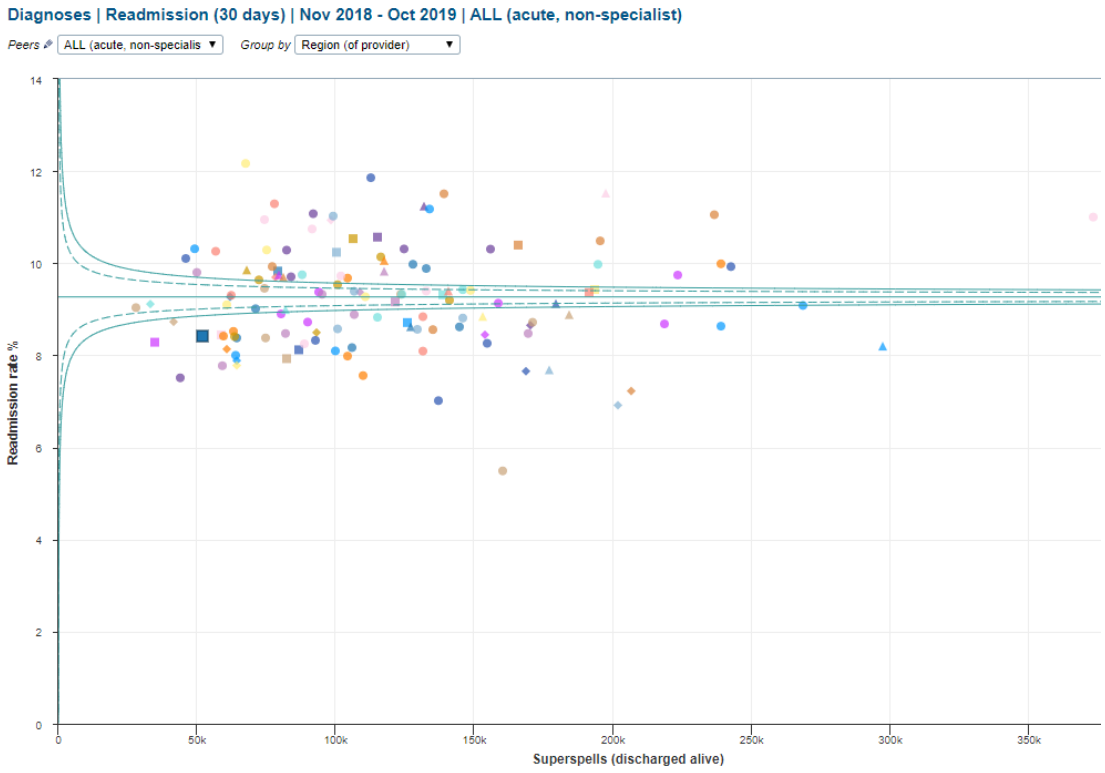
2.8 Getting it Right First-Time reviews in Q4

GIRFT reviews undertaken at DCH during this quarter are as follows;

- There were no GIRFT visits during Q4, and from March all future visits have been suspended.

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

2.7 Readmission to hospital within 30 days – lower is better



2.8 Dr Foster Safety Dashboard

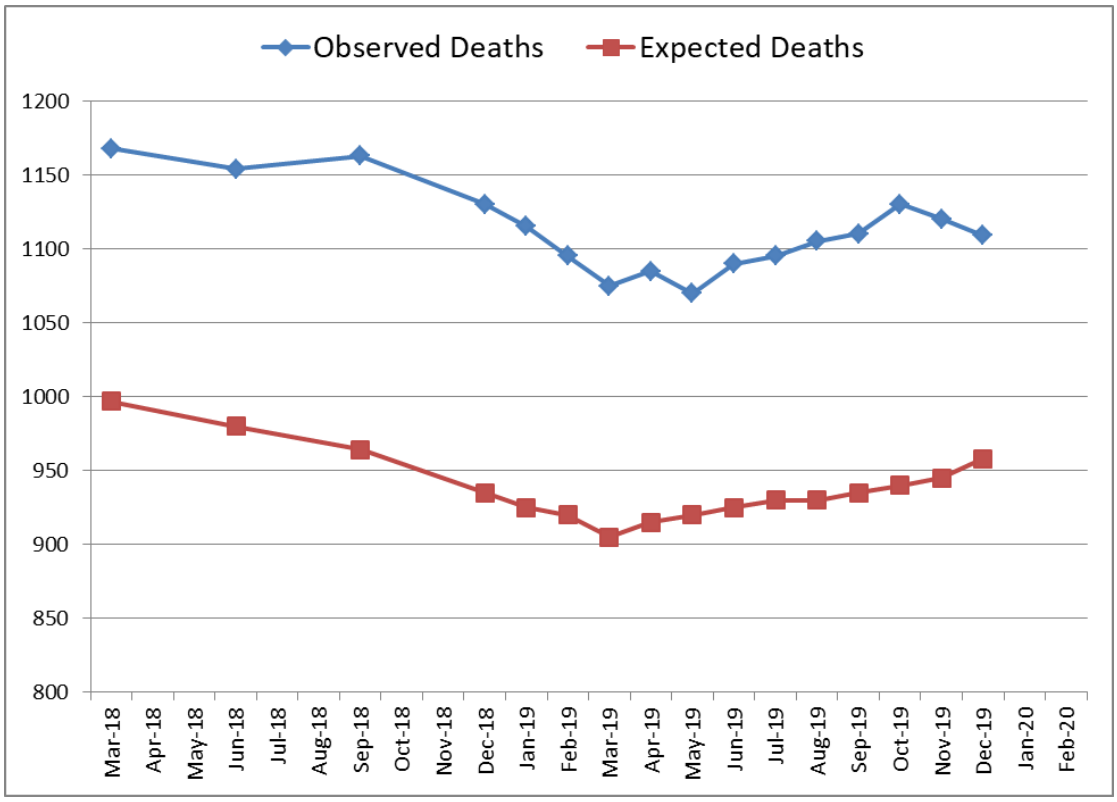
Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	41119	66	64.8	1.6	1.6	101.8	
Deaths after surgery	227	22	14.3	96.9	63.1	153.6	
Deaths in low-risk diagnosis groups	21764	13	9.8	0.6	0.4	133.0	
Decubitus ulcer	4803	185	259.6	38.5	54.0	71.3	
Infections associated with central line	7744	0	0.5	0	0.1	0.0	
Obstetric trauma - caesarean delivery	428	7	1.8	16.4	4.3	379.1	
Obstetric trauma - vaginal delivery with instrument	131	10	8.8	76.3	67.3	113.4	
Obstetric trauma - vaginal delivery without instrument	792	19	22.6	24.0	28.5	84.2	
Postoperative haemorrhage or haematoma	16354	5	5.8	0.3	0.4	85.7	
Postoperative hip fracture	21788	3	1.2	0.1	0.1	241.6	
Postoperative physiologic and metabolic derangement	14329	3	1.9	0.2	0.1	158.6	
Postoperative pulmonary embolism or deep vein thrombosis	16484	34	37.0	2.1	2.2	91.9	
Postoperative respiratory failure	13248	9	10.3	0.7	0.8	87.6	
Postoperative sepsis	284	0	3.9	0	13.8	0.0	
Postoperative wound dehiscence	426	0	0.3	0	0.8	0.0	

The Dr Foster safety 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 (185 versus 260).

3.0 CODING

3.1 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 has been rising over the past 9 months suggesting that coding accuracy overall is probably improving. The graph below plots Observed (actual) deaths and Expected deaths against rolling 12 month time points.



3.2 PWC Artificial Intelligence

PWC have produced an AI model to assist Trusts in understanding issues underlying 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 have led to a request for PWC to submit an options paper for future collaboration and pricing over a 6 month initial period. This paper is expected within the current month.

4.0 LEARNING FROM DEATHS

4.1 Structured Judgement Reviews

Although the Hospital mortality Group has continued to meet (virtually) over the past 2 months all work on SJRs has been temporarily suspended (as in all Trusts), and so it has not been possible to collate accurate data for this report. The next Quarterly Report will include this omitted data.

4.2 Working with Families

The End of Life team have co-designed improved information leaflets to bereaved families. All bereaved relatives now have the opportunity to discuss their relative's death with a Medical Examiner. Currently during the CoVID-19 crisis the Medical Examiner numbers are reduced to 2 but they continue to provide a full 5 days service between them.

5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

No new QI projects have yet been initiated as a result of the recent CoVID-19 pandemic.

6.0 MORBIDITY and MORTALITY MEETINGS

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.

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 11 new Coroner's inquests being opened in the period 01.01.20 – 31.03.20. During Quarter 4, the Trust had 24 inquests listed from previous quarters to be heard. Of these 24, 7 were heard as documentary inquests, with staff having to attend to give evidence in 12 cases, two cases were Pre-Inquest review hearings and 3 were adjourned. None has resulted in adverse criticism of standards of care and the Trust has not received any Regulation 28 letters.

8.0 SUMMARY

SHMI and HSMR remain higher than expected, with no clear trend towards deterioration or improvement over the recent 6 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 of SJRs and Learning from Deaths are being improved and this will be facilitated by the appointment of a new Family Services and Surgical Divisional Director – Mr Richard Sim - who takes up his post from 01/02/2020.

The Trust is currently undertaking a full review of its Quality Improvement processes, led by the Executive team.