

Ref: MA/TH  
Date: 19<sup>th</sup> August 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 **26<sup>th</sup> August 2020 at 08.30am to 9.35am** in the CEO's Office and via Lifesize. This meeting will be recorded and made available to the public via the Trust website.

The agenda is as set out below.

Yours sincerely

**Mark Addison**  
**Committee Chair**

**AGENDA**

1.	<b>Staff Story</b>	Presentation	HR Team	Note	8.30-8.50
2.	<b>FORMALITIES</b> to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	8.50-8.55
	a) Apologies for Absence: Victoria Hodges, Stephen Slough, Mark Warner (Emma Hallett attending)	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 29 <sup>th</sup> July 2020.	Enclosure	Mark Addison	Approval	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approval	
3.	<b>Integrated Performance Report including Committee Chair Input and Escalation Items</b> <ul style="list-style-type: none"> <li>• Quality</li> <li>• Performance</li> <li>• Finance</li> <li>• Workforce</li> </ul>	Enclosure	N Lucey/J Gillow I Robotham/S Tilton P Goddard/S Tilton E Hallett/V Hodges	Note	8.55-9.05
4.	<b>COVID-19 Update</b>	Verbal	Inese Robotham	Note	9.05-9.10
5.	<b>Gender Pay Gap</b>	Enclosure	Emma Hallett	Note	9.10-9.20
6.	<b>Adult Inpatient Experience Survey Results</b>	Enclosure	Nicky Lucey	Note	09.20-09.30

<b>7.</b>	<b>Decision Making Outside the Board</b>	Enclosure	Mark Addison / Trevor Hughes	Approve	9.30-9.35
	<b>CONSENT SECTION</b>				
	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.				
	Nil notified				
<b>8.</b>	<b>Any Other Business</b>				
	Nil notified				
<b>9.</b>	<b>Date and Time of Next Meeting</b>				
	The next Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at <b>8.30am</b> on the <b>30<sup>th</sup> September 2020</b> via Lifesize.				

**Minutes of a Meeting of the Board of Directors of Dorset County NHS  
Foundation Trust Held at 0900am on 29<sup>th</sup> July 2020 at the Board Room, Dorset  
County Hospital and via Lifesize.**

<b>Present:</b>		
Mark Addison	MA	Non-Executive Director ( <i>Chair</i> )
Sue Atkinson	SA	Non-Executive Director
Paul Goddard	PG	Director of Finance and Resources
Judy Gillow	JG	Non-Executive Director
Alastair Hutchison	AH	Medical Director
Nick Johnson	NJ	Director of Strategy, Transformation and Partnerships
Nicky Lucey	NL	Director of Nursing and Quality
Ian Metcalfe	IM	Non-Executive Director
Patricia Miller	PM	Chief executive
Inese Robotham	IR	Chief Operating Officer
Stephen Slough	SS	Chief Information Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
Mark Warner	MW	Director of Organisational Development (OD) and Workforce
<b>In Attendance:</b>		
Simon Bishop	SB	Governor
Sonia Gamblen	SG	Divisional Head of Nursing and Quality (item BoD20/098)
Emma Hoyle	EH	Associate Director of Infection Prevention and Control (item BoD20/109)
Ali Male	AM	Patient Experience and Engagement Lead (item BoD20/098)
Diane Smith	DS	Matron (item BoD20/098)
Trevor Hughes	TH	Head of Corporate Governance ( <i>Minutes</i> )
Gavin Maxwell	GM	Governor
Natalie Violet	NV	Corporate business Manager

<b>BoD20/098</b>	<b>PATIENT STORY</b>	
	<p>MA welcomed SG, AM and DS to the meeting.</p> <p>NL introduced the patient story noting that the patient wished to remain anonymous and that the complaint related to a time at the beginning of the COVID-19 pandemic when little was known about the disease and national guidance was being frequently updated.</p> <p>AM outlined the patient's story explaining that the patient was a member of staff who had a chronic lung condition and had required several hospital admissions as she had felt unwell and had experienced difficulty in breathing. Her complaint included efforts by the ambulance service to prevent hospital admission, delays in assessment by a Respiratory Consultant, being left by nursing staff to undertake self care and self administration of inhaled medication, lack of appropriate observation, poor environmental hygiene standards and hand hygiene by staff and delayed discharge due to failure to order take home medications. The patient also noted differing practices and attitudes between day and night staff and</p>	

	<p>between different wards in which she had been a patient.</p> <p>The patient had reflected that staff appeared reluctant to enter her cubicle and that there was little by way of distraction or occupation for patients on the ward. During her stay, the patient's lung diagnosis was revised although this had not been communicated to the GP on her discharge.</p> <p>SG advised that she was shocked by the complaint and contacted the complainant to apologise and inform them that their concerns would be fully investigated anonymously. The investigation was able to provide explanation on a number of the concerns raised and it was noted that national COVID guidance was frequently changed; occasionally several times per day, making communication and messaging to staff difficult. The need to balance support and promoting independence was also noted and it was acknowledged that the pandemic was frightening and stressful for all involved; staff, patients and carers, and that individual response to these circumstances would differ.</p> <p>The patient had reported that she was satisfied with the outcome of the investigation and thanked the team for taking the time to listen and respond to her concerns in a timely manner.</p> <p>NL outlined the learning gained from the complaint which had been shared across teams.</p> <p>JG commented on the importance of ward leadership in the maintenance of key standards. NL explained the significant impact of constantly changing guidance on effective leadership and noted the introduction of ward huddles, imagery to support awareness, further staff training and colour coded systems. PM emphasised the need for leaders to seek assurance on standards compliance and to prevent reoccurrence; instilling staff confidence in order that patients could feel they had been treated compassionately and respectfully.</p> <p>DU questioned action taken to provide a more stimulating environment and it was noted that puzzles etc. could now be brought in and patient WIFI and Ipads had been introduced. NL advised that the Patient Story presented in September would reflect a patient's experience at a later point in the pandemic. MA thanked SG, AM and DS for their attendance.</p>	
<b>BoD20/099</b>	<b>FORMALITIES</b>	<b>Action</b>
	The Chair declared the meeting open and quorate. Apologies for absence were received from Victoria Hodges, James Metcalfe and Richard Sim. MA reminded those present that the meeting would be recorded and published on the trust website and welcomed PM	

	to her first meeting following her return to work.	
<b>BoD20/100</b>	<b>Declarations of Interest</b>	
	There were no conflicts of interest declared in the business to be transacted on the Agenda.	
<b>BoD20/101</b>	<b>Minutes of the Meeting held on the 24<sup>th</sup> June 2020</b>	
	There were no questions or points of accuracy raised in respect to the Minutes of the meeting held on 24 <sup>th</sup> June 2020.	
	<b>Resolved: that the Minutes of the meeting held on the 24<sup>th</sup> June 2020 be approved as an accurate record.</b>	
<b>BoD20/102</b>	<b>Matters Arising: Action Log</b>	
	<p>No matters arising were raised in connection with the Action Log and the Board agreed to close items completed. MA noted the need to review and update paused actions and TH agreed to progress this with the Executive team. Review of the Board and committee workplans was noted to be currently underway.</p> <p>PM noted that the national Phase 3 letter was awaited and that this would inform committee and Board work plan priorities. Further discussion of these would take place at the Board Development Session in August.</p>	<b>TH</b>
	<b>Resolved: that the Action Log be received and approval be given for the removal of completed actions.</b>	
<b>BoD20/103</b>	<b>Chief Executive's Overview</b>	
	<p>PM invited questions on the report which was self explanatory. She highlighted that the Local Authority had received additional COVID funding but continued to report a significant deficit and noted the potential impact on adult and children's services. Initial care funding for patients following discharge was expected to continue although discharge arrangements could be impacted by winter pressures.</p> <p>SA congratulated PM on her appointment as Co-chair of the newly formed national BAME Chair and CEO Network. PM reported that the first meeting held earlier that month had been positive and that it was anticipated that the group would produce an article for publication in the autumn.</p>	
	<b>Resolved: that the Chief Executive's Overview be received and noted.</b>	
<b>BoD20/104</b>	<b>Integrated Performance Report</b>	
	<p><b>Quality</b> NL drew attention to the following key matters and invited questions:</p>	

	<ul style="list-style-type: none"> <li>• The CQC had provided a letter of assurance regarding the trust's COVID infection prevent and control arrangements;</li> <li>• The trust remained on routine CQC surveillance;</li> <li>• Quality performance had been maintained across the majority of indicators where data had been collected;</li> <li>• The trust had resumed responding to complaints;</li> <li>• the improvement on SMHI was noted;</li> <li>• the changing nature of the waiting list and work on patient flows to improve discharge.</li> </ul> <p>JG added that the Quality Committee would discuss learning from the pandemic in August and would also review committee priorities in light of the national Phase 3.</p> <p><b>Performance</b> IR presented key highlights:</p> <ul style="list-style-type: none"> <li>• A&amp;E had achieved the 95% standard for June and the quarter despite increasing activity;</li> <li>• fewer GP referrals had impacted A&amp;E attendances;</li> <li>• the additional work required in order to discharge patients to care homes had impacting timely discharge;</li> <li>• RTT compliance was declining and waiting times were growing despite use of the independent sector hospital – this picture was being reflected regionally and nationally;</li> <li>• Waiting list reviews focussed on those waiting for treatment in excess of 52 weeks and was based on clinical priority</li> <li>• Cancer target compliance was circa 70% and the nature of the waiting list had changed with people waiting longer;</li> <li>• Diagnostics performance had significantly improved to 58% - with the Endoscopy service increasing capacity;</li> <li>• Imaging (CT and MRI scans) had achieved the six week standard and this would be reflected in the August report.</li> </ul> <p>ST congratulated the ED performance improvement. IR provided regional benchmarking context to the performance picture, noting that neighbouring ED performance was also good. DCH cancer performance had benchmarked positively nationally. Current circumstances meant that comparisons with other Trusts could give a better idea of performance than comparison with the historic target.</p> <p>Further discussion was planned regarding performance of the Integrated Care System relative to South West partners.</p> <p><b>Finance</b> PG reported the June financial position as being on track to break even with 'True up' payments matching expenditure. He noted that non pay costs were increasing and reflective of higher bed</p>	<p>PM / NJ</p>
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	<p>occupancy rates and an increasing number of non-elective admissions.</p> <p>The outcome of regional capital bid submissions remained outstanding although £2.4m backlog maintenance funding had been received from the government £1.5bn national allocation and would be used to replace the fire alarm system.</p> <p>PG said the Trust's cash position remained better than forecast , but this was because of payments in advance which would be reclaimed before the year end.</p> <p>ST echoed that work continued on Finance and Performance Committee priorities.</p> <p>MA noted the ongoing uncertainty related to the future financial regime though a relatively benign position seemed likely to continue for the remainder of the financial year. IM commented on the impact of this in measuring performance and efficiency and he urged caution regarding the 'run rate' at the current time. The Board requested clarity on the run rate, efficiencies and associated potential risks in readiness for the following year.</p> <p><b>Workforce</b> MW provided a summary of workforce performance and highlighted:</p> <ul style="list-style-type: none"> <li>• An increase in workforce capacity with trust wide recruitment events now taking place;</li> <li>• Agency cost increases related to Registered Nurses and the expectation that this would continue;</li> <li>• Overseas nurses should be able join the trust from September 2020 although this would be governed by accommodation and training availability;</li> <li>• The Preceptorship Programme continued;</li> <li>• Examinations for 33 overseas nurses, cancelled due to the pandemic, had been rebooked;</li> <li>• The level of sickness absence reduced in May;</li> <li>• Staff COVID related absence remained static;</li> <li>• water bottles had been issued to staff and further rest room equipment was being provided;</li> <li>• a staff engagement tool seeking real time feedback was being trialled;</li> <li>• 3000 staff had been offered the COVID antibody test;</li> <li>• Swabbing continued for symptomatic staff;</li> <li>• national guidance regarding COVID risk assessment had extended the scope and needed to be completed;</li> <li>• periodic review of risk reports and incidents would be undertaken by the Workforce Committee commencing in August.</li> </ul>	PG
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	PM noted a recent HSJ publication that had identified DCH as being one of the lowest performing trusts nationally in respect to COVID risk assessment compliance and reporting. Discussion ensued about the need to identify gaps and stressing the need for efficient record keeping and completion of the task. The need for an automated processes and to learn from highly performing organisations was also noted.	<b>MW</b>
	<b>Resolved: that the Integrated Performance Report be received and noted.</b>	
<b>BoD02/105</b>	<b>COVID-19 Update – Overview Response Report</b>	
	<p>MA thanked IR for the report and it was noted that there had been no COVID positive patients or COVID related deaths over recent weeks.</p> <p>PM enquired whether discussion on the best use of accommodation needed to inform Winter Plan; requesting that a high level overview would be helpful. IR suggested that the Winter Plan would need to reflect varying scenarios.</p> <p>MA noted the increases in activity related to elective work and sought clarity on the comparative percentage of work currently being undertaken in light of current pressure being exerted by the centre. IR advised on the system-wide monitoring of relative performance and noted the need for additional investment and the additional staffing resource requirement in order to deliver significant activity increases. Modelling had been based on current funding and was below national expectations.</p>	
	<b>Resolved: that the COVID-19 Update be received and noted.</b>	
<b>BoD20/106</b>	<b>Learning from Deaths: Mortality Q1 Report</b>	
	<p>AH presented the report and noted that the SPC chart contained within the report had not translated in circulation.</p> <p>AH noted that the SHMI had fallen to within the expected range and that NHS Digital had indicated a further reduction in the current rate. He congratulated those staff involved in delivering the improvement. JG commended the work done and noted prior review of the report by the Quality Committee.</p> <p>MA commended the sustained and successful work over a long period of time and noted the significant improvements in coding. The contextual narrative had also offered very helpful assurance. He requested that the Board's thanks be communicated to staff. PM noted the support provided by the Director of Nursing and Quality and the contribution that the relationship established</p>	



	between AH and the regional team.	
	<b>Resolved: that the Learning from Deaths: Mortality Q1 Report be noted.</b>	
<b>BoD20/107</b>	<b>Equality, Diversity and Inclusion Annual Report</b>	
	<p>MA noted prior discussion of the report at the Workforce Committee.</p> <p>MW outlined the staff demographic locally and nationally. He noted the low numbers of staff declaring a disability and the disparity of results between reporting processes and the Staff Survey. The need to investigate differing success rates between BAME and white staff through the recruitment process and high numbers of disabled staff feeling pressurised to come to work when they were unwell was also noted.</p> <p>MW reported that the Action Plan, required as part of the report's submission, would further review in light of the planned review of strategic priorities.</p> <p>MA thanked MW for the report; noting that the Action Plan remained a work in progress, and invited wider comments. SA commended the analysis contained within the report and noted concerns around bullying and harassment experienced by BAME staff. She noted the established link between the level of control individuals had at work and their wellbeing and mortality and challenged whether the actions identified were sufficiently far reaching. SA urged wider discussion of the strategy by the Board and the need to recognise white privilege. Simple engagement with BAME staff would not be adequate.</p> <p>MA thanked SA for her thoughtful comments. IM remarked on the short action timescales contained within the Action Plan and noted that identified actions would need to be appropriately funded and effectively progressed.</p> <p>JG requested the inclusion of an assurance section within the plan and enquired whether system-wide action could also be undertaken; proposing a fast track leadership programme to develop band 4 and 5 staff as the ICS had received Health Education England development funding.</p> <p>DU raised the extent to which colleague appeared to have confidence to call out inappropriate and discriminatory behaviours and commented on the positive impact of wide engagement on culture.</p> <p>Discussion followed regarding the the lack of BAME clinicians</p>	<b>MW</b>

	<p>occupying leadership roles.</p> <p>EH joined the meeting.</p> <p>PM noted the need for cultural change and the work required on the discovery phase on culture. She commented on the recent Kings Fund publication that discussed the establishment and executive sponsorship of networks involving staff with protected characteristics and the inclusive leadership programmes being developed by Bristol University. DCH needed to take a dynamic approach to develop cultural change that would ensure people felt psychologically safe and provided a basis from which to move forward. PM noted the Board's commitment to making the required change and in developing the strategy and culture which would inform action planning.</p> <p>PM reported that she had received a request from the Communications Department to publish a statement regarding the Board's commitment to supporting the Black Lives Matter principles; confirming that this would not be a political statement. This was supported by the Board.</p> <p>PM outlined that the discovery phase would utilise the NHS Framework as this would help to determine next steps and funding requirements. Further discussion, including a timeframe, would be had at the Board Development Session in August.</p>	TH
	<b>Resolved that: the Equality, Diversity and Inclusion Annual Report be noted.</b>	
<b>BoD20/108</b>	<b>Board Assurance Framework and Corporate Risk Register</b>	
	<p>NJ noted that the report had been reported and discussed at the Risk and Audit Committee during the previous week and noted the requirement for further review in line with the strategy refresh.</p> <p>NL considered the risk register highlighted a number of risks which had been impacted by or were associated with the COVID pandemic.</p> <p>IM noted that there was a strategic planning review in the autumn, which would cover an update on BAF issues and that the current risks on the risk register, particularly related to COVID were effectively mitigated. However, there were medium term "likely" risks eg. growth of waiting lists in a second COVID wave, that could crystallise in the coming nine month period, which required further discussion and scenario planning and this would be covered in the discussion in Part 2 of the meeting.</p>	
	<b>Resolved that: Board Assurance Framework and Corporate</b>	

	<b>Risk Register be approved.</b>	
<b>BoD20/109</b>	<b>IPC Annual Report</b>	
	<p>EH attended for this item. NL highlighted that the report outlined a successful year where overall performance had been good. She noted the wider team approach taken to delivery of the infection prevention and control (IPC) agenda and commended the work of the Housekeeping team who took direction from the IPC team.</p> <p>EH reported ongoing work with the CCG on future performance trajectories and outlined performance relating to MRSA and C Diff infections.</p> <p>MA acknowledged the comprehensive report and noted the collaborative work surrounding the COVID response. JG reflected the positive comments made at Quality Committee. PM commended the IPC team for providing examples of outstanding practice that others could role model. AH also commended the team and commented on the levels of COVID in hospitals and transmission rates in partner organisations. DCH had had no COVID positive cases and had no hospital transmission of the infection throughout the crisis period.</p> <p>NL summarised the Emergency Support Framework arrangements in place with the CQC arrangements. Hospital COVID Transmission formed part of the CQC framework arrangements. SA suggested that the absence of COVID transmission within DCH should be more widely communicated. EH commented that a summary of the report would be publicised more widely and with regional networks.</p> <p>MA thanked the IPC and Housekeeping teams on behalf of the Board.</p> <p>EH left the meeting.</p>	
	<b>Resolved that: the IPC Annual Report and discussion be noted.</b>	
	<b>CONSENT SECTION</b>	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
<b>BoD20/110</b>	<b>Responsible Officer/Revalidation Annual Report</b>	
	<b>Resolved that: the Responsible Officer/Revalidation Annual Report be noted.</b>	
<b>BoD20/111</b>	<b>Combined Safeguarding Annual Report</b>	

	<b>Resolved that: the Combined Safeguarding Annual Report be noted.</b>	
<b>BoD20/112</b>	<b>Communications Update</b>	
	NL drew attention to the update and noted the excellent work of the small Communications team; noting the Staff Survey and learning and innovation work throughout the COVID period.	
	<b>Resolved that: the Communications Update be noted.</b>	
<b>BoD20/113</b>	<b>Dorset HealthWatch Annual Impact Report</b>	
	The Board acknowledged receipt of the report and noted prior discussion at Quality Committee. MA, PM and NL noted a planned meeting with the Chair of HealthWatch.	
	<b>Resolved that: the Dorset HealthWatch Annual Impact Report be noted.</b>	
<b>BoD20/114</b>	<b>Any Other Business</b>	
	It was noted that the Board would continue to meet each month with development sessions occurring additionally on alternate months.	
<b>BoD20/115</b>	<b>Date and Time of Next Meeting</b>	
	The next meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust will be held on <b>26<sup>th</sup> August 2020</b> at <b>08.30am</b> via Lifesize.	

Signed by Chair ..... Date .....

**Action Log – Board of Directors.**

 Presented on: 26<sup>th</sup> August 2020

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
<b>Meeting Dated: 29<sup>th</sup> July 2020</b>						
<b>BoD20/102</b>	<b>Matters Arising: Action Log</b>	Review and update of paused actions by the Executive Team	<b>TH</b>	<b>August 2020</b>	Review taking place in August Committee meetings.	Yes
<b>BoD20/104</b>	<b>Integrated Performance Report</b>	Further discussion regarding performance of the Integrated Care System relative to South West partners to be had.	<b>PM / NJ</b>	<b>September 2020</b>	Not Due	No
		To provide clarity on the current and future run rate and efficiencies and associated potential risks in readiness for the following year.	<b>PG</b>	<b>October 2020</b>	Awaiting financial guidance from the Treasury – revised due date to October	No
		COVID Risk assessments to be completed and recorded compliance levels reported	<b>MW</b>	<b>September 2020</b>	1500 COVID risk assessments had been undertaken including 82% of at risk staff and 77% of BAME staff. The aim is to complete remaining assessments by the end of August.	No
<b>BoD20/107</b>	<b>Equality, Diversity and Inclusion Annual Report</b>	Assurance section to be included within the Action Plan.	<b>MW</b>	<b>September 2020</b>	Not Due	No
		Further discussion of the cultural change requirements and discovery phase assessment framework to be had at August Board Development Session	<b>TH</b>	<b>August 2020</b>	Noted as an Agenda Item at Board Development Session in August	Yes

Meeting Dated: 25 <sup>th</sup> March 2020						
<b>BoD20/046</b>	-	The Board to come back to the staff survey results after the COVID-19 pandemic.	<b>TH</b>	<b>Post-COVID</b>	Preparations are underway for the 2020 Staff Survey. Feedback on this will be provided next year	Yes
Part One Actions from Previous Meetings						
<b>BoD20/001</b>	-	The Director of OD and Workforce to check with the education team what basic life support training was available Board members.	<b>MW</b>	<b>March 2020</b>	Basic Life Support training for Board members will be available from the Education Department from next year should Board members request it. Those staff trained are expected to act as first responders should there be an incident within the hospital.	Yes
<b>BoD20/006</b>	-	Report front sheets to be updated to include risk appetite statement and social values.	<b>PM/TH</b>	<b>September 2020</b>	Draft currently in discussion	No
<b>BoD20/007</b>	-	Dates of the series of events being planned to celebrate the contribution of EU staff to be circulated to the Board once finalised.	<b>PM/TH</b>	<b>When available</b>	Paused due to COVID-19	
<b>BoD20/008</b>	-	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.	<b>TH - MR, JG, IM</b>	<b>March 2020</b>	Refreshed and re-prioritised work plans being discussed at August Committees	Yes
<b>BoD20/008</b>	-	The Wessex Deanery had made it explicit that they wanted a change in	<b>PM/MW</b>	<b>September 2020</b>	Will be resolved as part of the Job	No

		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.			Planning project and an update will be provided in September.	
<b>BoD20/008</b>	-	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.	<b>NJ</b>	<b>March 2020</b>	Superseded by <b>BoD20/104</b>	Yes
<b>BoD20/008</b>	-	Integrated Performance Report amendments: <ul style="list-style-type: none"> <li>the 9 Must-Dos needed refreshing in line with the new guidance,</li> <li>the Chief Executive to review the narrative and move away from performance reporting in siloes,</li> <li>the pan-Dorset quality dashboard to feed into the Performance Report once received approved by the Quality Committee.</li> </ul>	<b>PM</b>	<b>TBC</b>	Paused due to COVID-19	
<b>BoD20/009</b>	-	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.	<b>MW</b>	<b>March 2020</b>		
<b>Actions from Committees...(Include Date)</b>						



### Board Strategic Work Programme Items Suspended due to COVID-19

Meeting	Items from Work Plan	Update
April 2020	<ul style="list-style-type: none"> <li>• Social Value</li> <li>• Quality Improvement</li> <li>• Equality and Diversity</li> <li>• Wellbeing</li> <li>• Sustainability</li> </ul>	<ul style="list-style-type: none"> <li>• Reporting in October</li> <li>• Reporting in September</li> </ul>
May 2020	<ul style="list-style-type: none"> <li>• Estates Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Board updated in July - ongoing</li> </ul>
June 2020	<ul style="list-style-type: none"> <li>• Nil</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
July	<ul style="list-style-type: none"> <li>• Annual Complaints Report</li> <li>• Annual Clinical Audit Report</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>

# Balanced-Score Card Performance Report

Report to Board 26 August 2020

## Performance Summary:

The Trust over achieved against the four hour Emergency Access Standard (EAS) in July 2020 with performance of 96.4% (combined with MIU); current August performance (as at 14/08/20) is also above the standard at 95.59%. Performance of Type 1 activity was 94% which is a marked improvement compared to July 2019 when type 1 performance was 82%. In July 2020 the department achieved second lowest ambulance handover delays in the region with zero chargeable delays and only 5.5 SWAST resource hours lost for the whole of the month. 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. The modular build to increase the triage footprint has been delivered and will become operational at the end of August 2020. ED activity has returned to expected levels of activity for this time of year; there were 4,049 attendances of which 1,532 were by ambulance. The RTT constitutional standard was not achieved and the performance deteriorated further – 37.17% versus 40.37% in June 2020. Total waiting list increased by 504 patients and total backlog increased by 470 patients. There were 1030 patients waiting over 52 weeks at the end of July 2020 with highest numbers in Orthopaedics, Oral Surgery and Ophthalmology. Elective admissions to the DCH site increased by 9.37% in July 2020 compared with June 2020, however this still remains 24.47% below pre-COVID activity levels (January 2020). The trust continues to utilise private sector capacity made available at BMI Winterbourne and it is anticipated that the current contractual arrangements with BMI Winterbourne will continue till at least October 2020. In addition a system-wide proposal for additional Orthopaedic activity (circa 400 cases) at New Hall Hospital in Wiltshire has been worked up and is currently with NHSE/I. The Trust's performance against the 62 day cancer standard currently stands at 70.00% and will not be finalised until the first week of September. Total 62 day cancer PTL stands at 815 compared to 610 as at the end of June 2020, however, the number of patients waiting over 62 days has decreased from 126 to 52. The main reasons for extended waiting times remain either patients choosing to delay diagnostics/treatments 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 did not achieve the 2 week wait standard for breast symptomatic and all cancers (58.1% and 69.2% respectively); this is reflective of referral numbers approaching pre-COVID levels and capacity constraints in a number of specialties, mainly breast and dermatology. Performance against the 6 week diagnostic standard was 60.08 %, a marginal improvement on 58.33% compared to June 2020. It has to be noted that there has been significant improvement in a number of modalities, mainly CT, MRI and sleep studies. This positive impact has been negatively offset by an increase of waiting list in Audiology and non-obstetric ultrasound.

## Main Performance Risks facing the Trust in 2020/21

Quality and Access risks:

- ED attendances are starting to return to historic levels of activity and whilst 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 this is now extended to the end of September. Beyond that period there will be some changes to the current process. The original changes include:

- Suspension of the National Tariff Payment System (PbR), which means that the Trust receives fixed income without any variation for patient activity
- Business Planning has been suspended and Trusts given a plan for the period based on historic run rate
- Payments for additional costs relating to COVID 19 which are reimbursed separately
- A “True Up” payment for Trusts to maintain a breakeven position
- System wide Capital spend targets

The anticipated changes from the 1<sup>st</sup> October have been confirmed in the recently published phase 3 letter and include the cessation of the ‘true up payments’ and moving the COVID 19 costs to a fixed sum based on historic spend. The detail of what this means to the Trust in income terms for the remainder of the financial year is not expected until the end of August or the beginning of September. Whilst the existing process has ensured that the Trust has reported a breakeven position to date, the anticipated changes are likely to increase the risk of the Trust continuing to deliver this performance.

The Trust has reported a £8k deficit position for July 2020, after including a “True Up” payment assumed from NHS England of £1.453 million. This amount is to cover the additional costs of the Trust’s COVID19 response (£0.880 million) in the month and a residual balance of expenditure over income (£0.573 million). Receipt of this funding will only be confirmed in mid- September 2020.

The year to date performance represents a £0.082 million deficit which is entirely driven by depreciation on donated assets which does not qualify for ‘true up’ funding. The regulator adjusts for this and effectively considers the Trust to be at break even.

The cash balance at 31 July 2020 was £22.312 million as a result of the Trust continuing to be paid one month in advance.

## Escalations from August Board Sub-Committees

### Workforce Committee

- Noted increased patient acuity and bed occupancy rates and the potential impact on bank and agency staffing expenditure;
- COVID-19 risk assessments completed for high risk (82%) and BAME (77%) staff. Completion of remaining assessments was anticipated by the end of August 2020;
- Wellbeing funding is available to support counselling and reverse mentoring schemes for those disproportionately affected by COVID-19;
- Noted ongoing work to better understand and address the gender pay gap;
- Considered the Workforce Plan challenges and interdependencies with other plans and funding arrangements – particularly the development of new roles, winter pressures and the identification of priorities as funding and planning arrangements change nationally;
- The workforce risk report was reviewed and included discussion of risks, incidents and claims;
- Discussion of the Consultant recruitment process took place and the committee agreed to reimburse reasonable expenses to facilitate co-ordinated and managed pre-interview visits;

### Quality Committee

- Progress update on timely EDS completion project
- Thanks to be passed on to all the staff whose goodwill in picking up additional weekend shifts had maintained the turnaround times and reporting of COVID 19 samples
- Excellent recruitment levels for the SIREN study, putting the hospital in the top 10% of Trusts in the Wessex region
- Issues regarding displaced services and staff wellbeing, particularly in the Family Services and Surgical Division
- National Inpatient Survey 2019 results (on Board agenda for noting)

### Finance and Performance Committee

- Activity and bed occupancy levels are increasing as referral demand increases impacting Referral to Treatment timescale compliance;
- The Emergency Department standard has been met for three consecutive months;
- A clinic typing backlog was noted due to an IT failure and was being actively prioritised and managed. Technology solutions were under consideration;
- Cancer service performance benchmarked well with system partners, supported by improved performance in diagnostic services;
- A new ultrasound machine is being procured to address the activity backlog;
- Noted that the waiting lists were regularly reviewed and prioritised based on clinical need;
- The new fixed income financial regime for the NHS will come into effect on the 1<sup>st</sup> October 2020 and is based on national performance targets, presenting a risk to the trust as the cost base increased;
- Future capital funding arrangements remain unclear;
- Approval was given to the outline business case to acquire staff accommodation to support delivery of the Workforce Strategy and reduce agency expenditure;

- The committee recommend the Critical Infrastructure Replacement plan to the Board for approval;
- The committee approved investment in the pan Dorset Maternity Digital Services Business Case;
- The committee recommend that the award of tender to replace the fire alarm system to the Board for approval.

## INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

### Safe

- There have been no Never events reported during this period
- There were no falls resulting in severe harm during this reporting period
- Overall IPC standards maintained
- There has been a slight increase in the detection of C-difficile; full analysis being undertaken

### Effective

- Update on Stroke services provided to Quality committee by Urgent and Integrated Division. Pilot of discharge rehabilitation pathway for stroke at Yeatman Community Hospital commenced.
- Electronic discharge summaries – update to be provided by the Medical Director

### 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 (discussed at previous Quality Committee and highlighted to Trust Board)

### Responsive

In July 2020 the following standards were met:

- Emergency Access Standard (combined with MIU)
- All Cancers – 31 Day Diagnosis to First Treatment
- 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 place for gradual restart of activity
  - Utilisation of Independent Sector capacity at BMI Winterbourne
  - Insourcing has commenced in Ophthalmology
  - Proposal to utilise New Hall Hospital's capacity for Orthopaedics submitted to NHSE/I
  - Significant interdependencies with PPE and consumable availability
  - Latest NICE guidance in relation to self-isolation and swabbing requirements to be implemented from September 2020
- 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
  - Backlog has decreased significantly, however a proportion of patients are choosing to delay diagnostics/treatment
  - 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
- Two week wait - all cancers and breast symptomatic
  - Patient choice to delay treatment in a small number of cases
  - Increase in referral numbers particularly in skin and breast
  - Dermatology locum secured, due to commence at the end of August
- Diagnostic 6 week wait
  - MRI and CT backlog has been cleared and the modalities are booking at five weeks
  - Additional endoscopic capacity has been insourced and commenced at the end of May 2020
  - Utilisation of all available independent sector diagnostic capacity
  - System wide recovery work on reducing audiology backlog

**Well Led**

Total workforce capacity (substantive plus bank) increased by 16.14 FTE in Month 04 and was 294.64 FTE above prior year. Substantive workforce capacity increased in Month 04 (+9.77 FTE) and was 261.64 FTE above prior year.

Agency spend increased by £74.1k largely due to an increase of £58.6k in qualified nursing, and £8,640 in consultant staff. A reduction of £9,458 occurred in therapeutic and technical staff which had seen an increase the previous month. The monthly spend included Covid related agency spend, and net of that, agency spend was £448K which was £96K below the corresponding figure for M04 2019/20.

In terms of nursing trajectories, we are now expecting the 23 overseas nurses to be able to join the Trust from mid-September. This is likely to be in 3 cohorts over 3 months to ensure we are able to support the overseas nurses appropriately. Continual review of quarantine guidelines is being undertaken in order to fully facilitate any required quarantine periods on arrival.

The sickness absence rate for Month 3 (June) decreased by 0.07% to 3.05% which is below the Trust target of 3.3%. The annual appraisal rate (i.e. the percentage of the substantive workforce having received a performance appraisal within the previous 12 months) decreased by 1% to 72%, which is below the Trust target



Metric	Threshold/Standard	Type of Standard	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Q1	Q2	YTD	Movement on Previous Period	12 Month Trend
<b>Safe</b>													
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)	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	0 (0.0)	2 (0.3)	0 (0.0)	0 (0.0)	1 (0.2)	3 (0.5)	1 (0.1)	3 (0.5)	4 (0.2)	↓	
NEW Harm Free Care (Safety Thermometer)	95%	Local Plan	94.1%	94.4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Never Events	0	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	N/A	For monitoring purposes only	0	3	1	0	0	0	1	1	1	N/A	
Duty of Candour - Cases completed	N/A	For monitoring purposes only	0	0	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	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	2	2	2	4	2	3	8	3	11	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	10% reduction 2016/17 = 9.9	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	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)	1 (0.1)	1 (0.2)	2 (0.2)	0 (0.2)	0 (0.2)	3 (0.2)	0 (0.0)	3 (0.1)	↔	
Emergency caesarean section rate			12.2%	16.2%	14.5%	15.0%	17.5%	15.5%	15.7%	15.5%	15.7%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (ED)	90%	2018/19 COUIN target 2019/20 Contractual (National Quality Requirement)	96.2%	76.9%	N/A	N/A	N/A	N/A	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 COUIN target 2019/20 Contractual (National Quality Requirement)	100%	100%	N/A	N/A	N/A	N/A	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 COUIN target 2019/20 Contractual (National Quality Requirement)	95.0%	85.9%	N/A	N/A	N/A	N/A	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 COUIN target 2019/20 Contractual (National Quality Requirement)	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	
<b>Effective</b>													
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)	2	N/A	N/A	N/A	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]	≤1.14 (ratio between observed deaths and expected deaths)	Contractual (Local Quality Requirement)	1.14	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator HSMR from Dr Foster - Rolling 12 months	100	Contractual (Local Quality Requirement)	118.0	118.4	N/A	N/A	N/A	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)	116.6	119.4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Stroke - Overall SSNAP score	C or above	Contractual (Local Quality Requirement)	N/A	N/A	N/A	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)	43.5%	44.1%	31.8%	31.7%	35.7%	21.5%	33.1%	21.5%	29.5%	↓	
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%	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%	78.6%	57.1%	84.6%	50.0%	70.0%	62.2%	70.0%	63.6%	↑	
<b>Caring</b>													
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	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	N/A	For monitoring purposes only	39	24	10	17	14	24	41	24	65	↓	
Complaints - Percentage response timescale met	Dec '18 = 95%	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	↔	
Friends and Family - Inpatient - Recommend	96%	Mar-18 National Average	97.7%	97.1%	100.0%	100.0%	98.9%	97.8%	98.7%	97.8%	98.7%	↓	
Friends and Family - Emergency Department - Recommend	84%	Mar-18 National Average	86.9%	91.4%	93.1%	90.4%	92.0%	91.6%	91.7%	91.6%	91.7%	↓	
Friends and Family - Outpatients - Recommend	94%	Mar-18 National Average	94.4%	93.8%	91.9%	91.2%	91.7%	93.0%	92.0%	93.0%	92.0%	↑	
Number of Hospital Hero Thank You Award applications received	2016/17 = 536 (44.6 per month)	Local Plan (2016/17 outturn)	14	10	11	N/A	N/A	N/A	11	0	11	↑	

Metric	Threshold/ Standard	Type of Standard	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Q1	Q2	YTD	Movement on Previous Period	12 Month Trend
<b>Responsive</b>													
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month')	92%	Contractual (National Operational Standard)	65.6%	60.7%	52.6%	46.4%	40.4%	37.2%	40.4%	37.2%	37.2%	↓	
RTT Incomplete Pathway Waiting List size	11,991		15,791	15,190	14,479	14,210	14,182	14,686	14,182	14,686	14,686	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	93%	Contractual (National Operational Standard)	87.6%	89.0%	81.9%	95.5%	82.1%	69.2%	86.4%	69.2%	80.9%	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	93%	Contractual (National Operational Standard)	100.0%	84.2%	100.0%	93.5%	96.8%	58.1%	95.9%	58.1%	84.8%	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	96%	Contractual (National Operational Standard)	97.6%	95.0%	97.5%	91.5%	98.7%	98.8%	95.8%	98.8%	96.6%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	94%	Contractual (National Operational Standard)	100.0%	90.9%	88.9%	100.0%	100.0%	100.0%	94.4%	100.0%	96.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	98%	Contractual (National Operational Standard)	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	98%	Contractual (National Operational Standard)	100.0%	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)	86.1%	90.5%	69.4%	71.6%	69.7%	70.0%	70.2%	70.0%	70.2%	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	90%	Contractual (National Operational Standard)	16.7%	100.0%	76.5%	33.3%	-	0.0%	70.0%	0.0%	70.0%	↓	
% patients waiting less than 6 weeks for a diagnostic test	99%	Contractual (National Operational Standard)	96.0%	84.4%	40.9%	40.8%	58.4%	60.1%	56.7%	60.1%	51.3%	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	95%	Contractual (National Operational Standard)	85.9%	88.7%	89.4%	92.8%	93.8%	93.6%	92.3%	93.6%	92.7%	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from	95%	Contractual (National Operational Standard)	93.2%	94.1%	93.2%	95.4%	96.3%	96.4%	95.2%	96.4%	95.6%	↑	
<b>Well Led</b>													
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	N/A	N/A		
Sickness rate (one month in arrears)	3.3%	Internal Standard reported to FPC	3.76%	5.81%	4.91%	3.12%	3.05%	N/A	3.69%	N/A	3.7%	↑	
Appraisal rate	90%	Internal Standard reported to FPC	83%	77%	82%	75%	71%	72%	76%	82%	75%	↑	
Staff Turnover Rate	8 - 12%	Internal Standard reported to FPC	10.3%	10.1%	9.4%	9.4%	8.9%	9.4%	9.3%	9.4%	9.3%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,520.8	2571.40	2,620.5	2,632.5	2,639.6	2,649.4	2,630.9	2,649.4	2,637.1	N/A	
Vacancy Rate (substantive)	<5%	Internal Standard reported to FPC	9.2%	7.8%	7.7%	5.8%	5.7%	6.0%	6.4%	6.4%	6.3%	↓	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	9,725.3	10,035.6	10,537.1	10,658.3	10,638.5	10,452.2	10,611.3	10,452.2	10,571.5	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	N/A	Internal Standard reported to FPC	0	1	0	0	0	0	0	0	0	N/A	
Essential Skill Rate	90%	Internal Standard reported to FPC	89%	90%	88%	87%	87%	88%	87%	88%	87%	↑	
Elective levels of contracted activity (activity)	2019/20 = 30,584 2548/month		1,973	2,244	603	849	1,286	1,383	2,738	1,383	4,121	↑	
Elective levels of contracted activity (£) Including MFF	2019/20 = £30,721,866 £2,560,155/month		£2,147,020	£2,269,226	£639,034	£825,271	£1,220,687	£1,412,734	£2,684,992	£1,412,734	£4,097,726	↑	
Surplus/(deficit) (year to date)	2020/21 = Breakeven YTD M4 = Breakeven	Local Plan	(1,652)	205	0	0	0	0	0	0	0	N/A	N/A
Cash Balance	2020/21 - 1,784 M4 = 4,592		14,020	7,335	21,269	N/A	21,657	22,312	21,657	22,312	22,312	↑	
CIIP - year to date (aggressive cost reduction plans)	2020/21 = N/A under current plan YTD M1 = N/A	Local Plan	5,085	5,710	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A
Agency spend YTD	2020/21 = No Annual value YTD M4 = 2,656		6,499	7,837	806	1,393	2,009	2,700	2,009	2,700	2,700	N/A	N/A
Agency % of pay expenditure	2020/21 = No Annual value YTD M4 = 5.9%		5.5%	7.8%	6.7%	5.8%	5.6%	5.6%	5.6%	5.6%	5.6%	↔	

**Movement Key**  
Favourable Movement  
Adverse Movement  
No Movement

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↓  
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Achieving Standard  
Not Achieving Standard

**Key Performance Metrics Summary**

	Metric	Standard	Jun-20	Jul-20
<b>Quality</b>	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	1 (0.2)	1 (0.2)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	16	1 (0.2)	3 (0.5)
	Never Events	0	0	0
	Serious Incidents declared on STEIS (confirmed)	51 (4 per month)	0	0
	SHMI - Rolling 12 months, 4 months in arrears (Mar-19 to Feb-19)	≤1.14	1.14	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-19 to Mar-20)	100	118.4	
<b>Performance</b>	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	92%	40.4%	37.2%
	RTT Incomplete Pathway Waiting List size	11,991	14,182	14,686
	All cancers maximum 62 day wait for first treatment from urgent GP referral	85%	69.7%	70.0%
	Maximum 6 week wait for diagnostic tests	99%	58.4%	60.1%
	ED maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Including MIU/UCC activity from November 2016)	95%	96.3%	96.4%
<b>Finance</b>	Elective levels of contracted activity (£)	2019/20 = £30,721,866 £2,560,155/month	1,220,687	1,412,734
	Surplus/(deficit) (year to date)	2020/21 = Breakeven YTD M4 = Breakeven	0	0
	CIP - year to date (aggressive cost reduction plans)	2020/21 = N/A under current plan YTD M1 = N/A	N/A	0
	Agency spend YTD	2020/21 = No Annual value YTD M4 = 2,656	2,009	2,700

Rating Key



<b>Title of Meeting</b>	<b>Board of Directors</b>
<b>Date of Meeting</b>	<b>26 August 2020</b>
<b>Report Title</b>	<b>2020 Gender Pay Gap Findings</b>
<b>Author</b>	<b>Bernadette Pritchard, Inclusion and Wellbeing Lead</b>
<b>Responsible Executive</b>	<b>Mark Warner, Director of Workforce and Organisational Development</b>
<b>Purpose of Report (e.g. for decision, information)</b> For information and to note actions set out in the Action Plan.	
<b>Summary</b> <p>All UK employers have a legal requirement to publish their gender pay data on an annual basis. However, <b>Due to COVID-19, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) have suspended enforcement of this year's gender pay gap reporting deadline.</b></p> <p>The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages; a mean average and a median average. In simple terms, the mean is the average hourly rate and the median is the mid-point hourly rate for men and for women in the workforce. The mean figure is the figure most commonly used.</p> <p>This report for Dorset County Hospital NHS Foundation Trust reviews the latest data set, which covers the 12 month period ending 31 March 2020.</p>	
<b>Paper Previously Reviewed By</b> Workforce Committee, 17 August 2020	
<b>Strategic Impact</b> Data received through the gender pay gap analysis provides a source to inform improvements to leadership and management practices and changes to the working environment. Research suggests that there is a gender pay gap even before the arrival of a first child. Unequal sharing of care responsibilities contributes to a higher proportion of women taking part-time work, which is generally lower paid. Consequently the gender pay gap widens, particularly for those employees over 40.	
<b>Risk Evaluation</b> The analysis of the gender pay gap results has assisted in identifying key areas of concern and potential risk and these were incorporated into the action plan.	
<b>Impact on Care Quality Commission Registration and/or Clinical Quality</b> No specific implications relating to the contents of the action plan.	

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<b>Governance Implications (legal, clinical, equality and diversity or other):</b> The gender pay gap results show the difference in the average pay between all men and women in the Trust.	
<b>Financial Implications</b> No specific implications relating to the contents of the action plan.	
<b>Freedom of Information Implications – can the report be published?</b>	Yes
<b>Recommendations</b>	Trust Board are asked to note the contents of this paper and the recommendations in response to the 2020 Gender Pay Gap analysis.

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## 1.1 The Trust's Overall Results

Across our entire workforce our mean gender pay gap is 31%. This means that the average hourly pay rate for men is 31% higher than for women. This is a two percentage point increase from 2018/19. Our overall median gender pay gap is 22% - this means that the mid-point hourly rate for men is 22% higher than for women, which is an eleven percentage point increase on 2018/19.

Our proportion of male and female staff should be taken into account when looking at our gender pay gap, as should the age range of our male and female workforce, as members of staff who have enjoyed long careers in the NHS can often be higher up the pay point scales than those who are just starting their careers.

## 1.2 The difference between gender pay and equal pay

It is important to be clear about the difference between gender pay and equal pay. The solutions to equal pay and gender pay are different. Closing the gender pay gap is a broader societal as well as organisational issue. Though we have a gender pay gap due to our disproportionate representation of men and women within the workforce (as reflected across the NHS), we are confident that we pay fairly in accordance with the nationally recognised Agenda for Change, Medical & Dental and our locally recognised Senior Manager and Director pay structures. The NHS Job Evaluation Scheme, part of the Agenda for Change NHS pay structure introduced in 2004 was developed as a means of determining pay bands for posts. The key feature in both the design and implementation of this scheme was to ensure equal pay for work of equal value. The scheme has been tested legally and has been found to be equal pay compliant

## 1.3 The six basic calculations the Trust is required\* to report:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;
- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment;
- proportion of males and females in each quartile band.

\*Deadline currently suspended by the GEO and EHRC – see front sheet summary.

- 1.4 As with any data analysis, the most critical aspect of the process is not just about reviewing the results but being clear about what needs to be done differently in future.

## 2.0 Purpose of this Report

- 2.1 This report will help the Trust to understand any underlying causes for their gender pay gap and take suitable steps to minimise it. Taking these steps will help us to continue to develop a reputation for being a fair and progressive employer, attracting a wider pool of potential recruits for vacancies and the enhanced productivity that can come from a workforce that feels valued and engaged in a culture committed to tackling inequality.

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### 3.0 Methodology

- 3.1 Colleagues from the Electronic Staff Record (ESR) team have developed reports which will help organisations calculate their GPG data. These are available via ESR and accessible via the dashboard of ESR Business Intelligence.

### 4.0 Gender Pay Gap Data

- 4.1 Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2020) are as follows:
- Our mean gender pay gap is 31%
  - Our median gender pay gap is 22%
  - Our mean bonus gender pay gap is 31%
  - Our median bonus gender pay gap is 50%
  - Our proportion of males receiving a bonus payment is 6%
  - Our proportion of females receiving a bonus payment is 0.5%
- 4.2 The table below shows the proportion of males and females in each of the quartile bands. (The quartile information is created by sorting all employees by their hourly rate of pay and then splitting the list into 4 equal parts to create 4 pay quartiles).

Number of employees   Q1 = Low, Q4 = High								
	2019/20				2018/19			
Quartile	Female	Male	Female %	Male %	Female	Male	Female %	Male %
1	628	126	83%	17%	590	170	78%	22%
2	616	138	82%	18%	649	130	83%	17%
3	654	100	87%	13%	657	112	85%	15%
4	459	296	61%	39%	504	266	65%	35%

The proportion of male and female employees in the lowest pay quartile is 83% female and 17% male, compared to the proportion of male and female employees in the highest pay quartile which is 61% female and 39% male.

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#### 4.3 Mean & Median Hourly Rates

Mean (Average) & Median Hourly Rates						
Gender	2018/19				2017/18	
	Avg. Hourly Rate 2019/20	Movement in Year	Median Hourly Rate 2019/20	Movement in Year	Avg. Hourly Rate 2018/19	Median Hourly Rate 2018/19
Male	£21.80	+£0.03	£15.97	+£0.59	21.77	15.38
Female	£14.99	-£0.44	£12.38	-£1.35	15.43	13.73
Difference	£6.81	£0.47	£3.59	£1.94	6.33	1.65
Pay Gap %	31%		22%		29%	11%

The Trust's mean gender pay gap is 31% in favour of men (women earn 31% less than men) compared to the national average of 17.3% in favour of men (source: Annual Survey of Hours and Earnings, Office for National Statistics, 2019).

Based on the Government's methodology, as of 31 March 2018 (latest figures), the NHS as a whole had a mean gender pay gap of 19%, and a median gender pay gap of 22%.

#### 4.4 Gender Bonus Pay Gap Results

For Gender Pay Gap calculations, our bonus payments relate to Clinical Excellence Awards only. These award consultants and academic GPs who perform 'over and above' the standard expected of their role. The present scheme was established in 2003. The administration of the scheme nationally is in the hands of the Advisory Committee on Clinical Excellence Awards. There are 12 levels of award. Levels 1-8 are awarded locally by employing NHS Trusts, and levels 10-12 (silver, gold and platinum) are awarded nationally

##### 4.4.1 Bonus Pay Summary

The table below shows the summary of male and female employees receiving a bonus payment. The only bonus payments paid by the Trust are local and national Clinical Excellence Awards, paid to eligible medical Consultants.

Bonus Pay Summary				
Gender	2019/20		2018/19	
	Avg. Pay	Median Pay	Avg. Pay	Median Pay
Male	16235.00	12064.00	12629.26	9048.00
Female	11202.28	6032.00	9704.59	3015.96
Difference	5032.72	6032.00	2924.67	6032.04
Pay Gap %	31%	50%	23.16%	66.67%

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#### 4.4.2 Bonus Ratio

The below table shows the proportion of males and females receiving a bonus payment

Bonus ratio						
	2019/20			2018/19		
Gender	Employees Paid Bonus	Total Relevant Employees	%	Employees Paid Bonus	Total Relevant Employees	%
Female	14	3111	0.45	15	2796	0.54
Male	54	924	5.85	55	830	6.33

#### 4.5 Understanding our Gender Pay Gap

While men make up only 18% of the workforce, there is a disproportionate number of males, 39% in the highest paid quartile.

The Trust's mean gender pay gap is 31% in favour of men (women earn 31% less than men) compared to the national average of 17.3% in favour of men (source: Annual Survey of Hours and Earnings, Office for National Statistics, 2019).

Based on the Government's methodology, as of 31 March 2018 (latest figures), the NHS as a whole had a mean gender pay gap of 19%, and a median gender pay gap of 22%.

This is not the same as saying women and men are being paid differently for doing the same job (which would be an equal pay issue).

At DCHFT, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff. This is reflected in our overall gender pay gap and, as a trust, we recognise that this is a generational and societal issue. We know, however, that an increasing number of women are choosing to pursue medicine and other previously male-dominated roles as a career.

51% of the population of England are women, and 55% of NHS England's upper quartile senior staff are women. However, 83% of employees in DCHFT's lower quartile are female. This demonstrates that a significant driver for the pay gap is a consequence of having a lower proportion of men in lower pay bands relative to their share of the population.

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## 4.6 Recommendations to address our Gender Pay Gap

### 4.6.1 Female consultants applying for Clinical Excellence Awards (CEAs)

- Further analysis to be undertaken on the gender split of eligible consultants who apply for and are successful in receiving CEAs over the last 5 years.

Proactive communications, publicity and training support has been offered by other Trusts with lower rates of female application to all consultants on how to apply for CEAs. Some trusts also offer a mentoring and buddying scheme for female and male consultants to encourage and support them with their CEA applications.

It is worth noting that national guidance relating to the 2020 CEA awards round has been issued and that due to the Covid-19 pandemic, the 2020 CEA monies are being split equally between every eligible Consultant. The CEA process after 2020 is being reviewed nationally, so this analysis will inform if we need to focus on supporting equity in applications to the new scheme

### 4.6.2 Supporting flexible working

- Further analysis to be undertaken on the gender split and difference in hourly rate between part time and full time workers.

The Trust has made rapid and positive progress in its flexible working offer since the start of the Covid-19 pandemic by increasing the number of roles that can be undertaken from home. We have also held a forum/drop-in to talk about flexible working opportunities in our staff restaurant, and created an online survey and our flexible working policy was reviewed.

## 4.7 The NHS People Plan

The plan, published on 30<sup>th</sup> July 2020, highlights the need for Flexible Working to become the norm' within the NHS. It lays out the following specific actions for employers which relate directly to gender pay gap:

- Be open to all clinical and non-clinical permanent roles being flexible.
- Cover flexible working in standard induction conversations for new starters and annual appraisals

Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade

- Board members must give flexible working their focus and support.
- Roll out the new working carers passport to support people with caring responsibilities (this is based on the work of West Yorkshire and Harrogate Health and Care Partnership)

## 4.8 Conclusions

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As a trust we are committed to supporting the career progression and ensuring equal opportunities for everyone within our workforce. We have a range of family friendly policies, supporting childcare, flexible working, and leave provision.

The Trust has made great strides over the past six months in its flexible working offer for staff. Our progress will be fortified by implementation of the actions in the NHS People Plan. This, along with the proposed work on CEAs and part-time workers will form our GPG Action Plan for 2020.

**APPENDIX A Table 1: Salary based on Full-time Equivalent**

\*Gender Pay Gap calculations by band group are expressed as a percentage in relation to the male salary. All values recorded as a negative (-) indicate that the Gender Pay Gap is in favour of the female workforce.

SPLIT BY GRADE – Based on Spinal value						
GRADE	2019/20			2018/19		
	MEAN AVG SALARY		2019/20 GAP	MEAN AVG SALARY		2018/19 GAP
	FEMALE	MALE		FEMALE	MALE	
Band 1	£17,652.00	£17,652.00	0.00%	£17,460.00	£17,460.00	0.00% equal
Band 2	£18,146.95	£18,074.82	-0.40% (in favour of female employees)	£17,965.19	£17,790.22	-0.98% (in favour of female employees)
Band 3	£19,736.40	£19,844.16	0.54% (in favour of male employees)	£19,315.11	£19,493.36	0.91% (in favour of male employees)
Band 4	£22,860.50	£22,583.06	-1.21% (in favour of female employees)	£22,131.48	£22,112.23	-0.09% (in favour of female employees)
Band 5	£27,524.63	£26,738.92	-2.85% (in favour of female employees)	£27,034.77	£26,430.90	-2.28% (in favour of female employees)
Band 6	£34,091.87	£34,216.48	-0.36% (in favour of male employees)	£33,211.89	£33,201.30	-0.03% (in favour of female employees)
Band 7	£41,363.98	£41,245.84	-0.29% (in favour of female employees)	£40,073.14	£39,631.24	-1.12% (in favour of female employees)
Band 8a	£48,074.44	£48,287.35	-0.44% (in favour of male employees)	£47,377.91	£47,506.18	0.27% (in favour of male employees)
Band 8b	£57,455.83	£56,945.00	-0.89% (in favour of female employees)	£56,098.39	£57,001.30	1.58% (in favour of male employees)
Band 8c, 8d, 9	£76,651.17	£76,297.67	-0.46% (in favour of female employees)	£73,323.38	£75,601.86	3.01% (in favour of male employees)
Ad- Hoc	£0.00	£0.00	0.00%	£85,142.96	£58,645.27	-45.18% (in favour of female employees)
Medical & Dental	£56,639.54	£72,963.10	22.37% (in favour of male employees)	£57,083.20	£71,614.48	20.29% (in favour of male employees)

Table 2: Actual Salary i.e. based on number of hours worked.

\*Gender Pay Gap calculations by band group are expressed as a percentage in relation to the male salary. All values recorded as a negative (-) indicate that the Gender Pay Gap is in favour of the female workforce.

SPLIT BY GRADE – Based on Spinal value						
GRADE	2019/20			2018/19		
	MEAN AVG SALARY		2019/20 GAP	MEAN AVG SALARY		2018/19 GAP
	FEMALE	MALE		FEMALE	MALE	
Band 1	£5,766.32	£12,647.48	54.41% (in favour of male employees)	£17,460.00	£17,460.00	0.00% equal
Band 2	£14,042.85	£15,565.33	9.78% (in favour of male employees)	£17,965.19	£17,790.22	-0.98% (in favour of female employees)
Band 3	£16,223.19	£18,457.55	12.11% (in favour of male employees)	£19,315.11	£19,493.36	0.91% (in favour of male employees)
Band 4	£20,891.59	£21,913.70	4.66% (in favour of male employees)	£22,131.48	£22,112.23	-0.09% (in favour of female employees)
Band 5	£22,783.55	£25,591.72	10.97% (in favour of male employees)	£27,034.77	£26,430.90	-2.28% (in favour of female employees)
Band 6	£27,061.91	£32,484.63	16.69% (in favour of male employees)	£33,211.89	£33,201.30	-0.03% (in favour of female employees)
Band 7	£35,304.03	£38,515.89	8.34% (in favour of male employees)	£40,073.14	£39,631.24	-1.12% (in favour of female employees)
Band 8a	£44,386.02	£47,029.83	5.62% (in favour of male employees)	£47,377.91	£47,506.18	0.27% (in favour of male employees)
Band 8b	£54,988.35	£53,401.16	2.89% (in favour of female employees)	£56,098.39	£57,001.30	1.58% (in favour of male employees)
Band 8c, 8d, 9	£69,391.47	£71,457.87	2.89% (in favour of male employees)	£73,323.38	£75,601.86	3.01% (in favour of male employees)
Ad- Hoc	£61,211.95	£99,182.38	38.28% (in favour of male employees)	£85,142.96	£58,645.27	-45.18% (in favour of female employees)
Medical & Dental	£49,101.87	£68,896.19	28.73% (in favour of male employees)	£57,083.20	£71,614.48	20.29% (in favour of male employees)

<b>Title of Meeting</b>	Board of Directors
<b>Date of Meeting</b>	26 August 2020
<b>Report Title</b>	Inpatient Survey 2019 Summary
<b>Author</b>	Neal Cleaver, Deputy Director of Nursing and Quality Ali Male, Patient Experience & Engagement Lead
<b>Responsible Executive</b>	Nicky Lucey, Director of Nursing and Quality






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

To provide a summary of the national inpatient survey 2019 report for Dorset County Hospital and provide historic and national comparison






**Summary**

In July 2020 the Picker Institute Europe national Inpatient Survey results became available.

**Key Improvements since 2018**

-  Procedure: explained how it had gone in an understandable way
-  Care: enough emotional support from hospital staff
-  Planned admission: specialist given all the necessary information
-  Doctors: got clear answers to questions
-  Discharge: told of danger signals to look for

**Issues to address**

-  Planned admission: was admitted as soon as necessary
-  Planned admission: admission date not changed by hospital
-  Nurses: knew which nurse was in charge of care
-  Overall: asked to give views on quality of care
-  Procedure: told how to expect to feel after operation or procedure

The Patient Experience Group has recognised that the areas in need of improvement regarding planned admissions are unlikely to be (easily) resolved within the current pandemic and national guidelines.

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<b>Paper Previously Reviewed By</b> Inpatient summary reviewed by Patient Experience Group 30/07/2020. Quality Committee, 18 August 2020	
<b>Strategic Impact</b> NHS Foundation Trusts are required to publish inpatient survey results. Using this feedback will help deliver further improvements to patient care. This relates to Strategic Objective 1 – Delivering outstanding services every day; Objective 3 – collaborative working with our patients and partners; and Objective 4 – Enabling and empowering staff.	
<b>Risk Evaluation</b> <ul style="list-style-type: none"> <li>Failure to act on the results of the inpatient survey will have a negative impact on both staff wellbeing and patient care and strategic objectives</li> </ul>	
<b>Impact on Care Quality Commission Registration and/or Clinical Quality</b> As the report of these priorities incorporates standards and metrics that are utilized by the CQC it will be important to note progress or exceptions to these standards.	
<b>Governance Implications (legal, clinical, equality and diversity or other):</b> Trust Boards must have oversight of the inpatient and staff survey results. Inability to achieve the improvements associated with these could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.	
<b>Financial Implications</b> None currently identified	
<b>Freedom of Information Implications – can the report be published?</b>	Yes
<b>Recommendations</b>	a) Note the report b) Support the Patient Experience Group leading on the Trust action plan



<b>Title of Meeting</b>	<b>Board of Directors</b>
<b>Date of Meeting</b>	<b>26 August 2020</b>
<b>Report Title</b>	<b>National Inpatient Survey 2019</b>
<b>Author</b>	Alison Male, Patient Experience & Engagement Lead Neal Cleaver, Deputy Director of Nursing and Quality

## 1. Introduction

This document summarises the findings from the NHS Inpatient Survey 2019, carried out by Picker, on behalf of Dorset County Hospital NHS Foundation Trust.

Picker was commissioned by 74 Inpatient organisations to undertake the Inpatient Survey. A total of 1250 patients from our Trust were invited to complete the questionnaire. 1192 patients were eligible for the survey, of which 640 returned a completed questionnaire, giving a response rate of 54% (compared to the Picker average response rate of 44%) and our previous 2018 response rate of 54%.

<b>DCH 2019</b>	<b>National Average</b>	<b>Top 5 scores (compared to average)</b>
<b>65%</b>	60%	Q50. Discharge: was not delayed
<b>84%</b>	79%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation
<b>66%</b>	62%	Q9. Admission: did not have to wait long time to get to bed on ward
<b>85%</b>	82%	Q21+. Hospital: got enough help from staff to eat meals
<b>81%</b>	78%	Q54+. Discharge: got enough support from health or social care professionals

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DCH 2019	DCH 2018	National Average	Most improved from last survey
93%	89%	91%	Q47. Procedure: explained how it had gone in an understandable way
86%	84%	85%	Q38+. Care: enough emotional support from hospital staff
99%	96%	97%	Q8+. Planned admission: specialist given all the necessary information
95%	93%	95%	Q23+. Doctors: got clear answers to questions
63%	61%	64%	Q60+. Discharge: told of danger signals to look for

DCH 2019	National Average	Bottom 5 scores (compared to average)
54%	72%	Q6. Planned admission: was admitted as soon as necessary
71%	78%	Q7. Planned admission: admission date not changed by hospital
75%	80%	Q30. Nurses: knew which nurse was in charge of care
10%	14%	Q70+. Overall: asked to give views on quality of care
85%	89%	Q46. Procedure: told how to expect to feel after operation or procedure – NB: <i>on the Trust National Survey action plan although not complete prior to the 2019 Survey</i>






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DCH 2019	DCH 2018	National Average	Least improved from last survey
54%	74%	72%	Q6. Planned admission: was admitted as soon as necessary
71%	81%	78%	Q7. Planned admission: admission date not changed by hospital
60%	68%	59%	Q19+. Hospital: food was very good or good
10%	17%	12%	Q52. Discharge: delayed by no longer than 1 hour
68%	73%	69%	Q33. Care: staff did not contradict each other

## Overall results:

### Key Improvements since 2018






-  Procedure: explained how it had gone in an understandable way
-  Care: enough emotional support from hospital staff
-  Planned admission: specialist given all the necessary information
-  Doctors: got clear answers to questions
-  Discharge: told of danger signals to look for

### Our core strengths

-  Discharge: was not delayed
-  Discharge: staff discussed need for additional equipment or home adaptation
-  Admission: did not have to wait long time to get to bed on ward
-  Hospital: got enough help from staff to eat meals
-  Discharge: got enough support from health or social care professionals

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## Issues to address

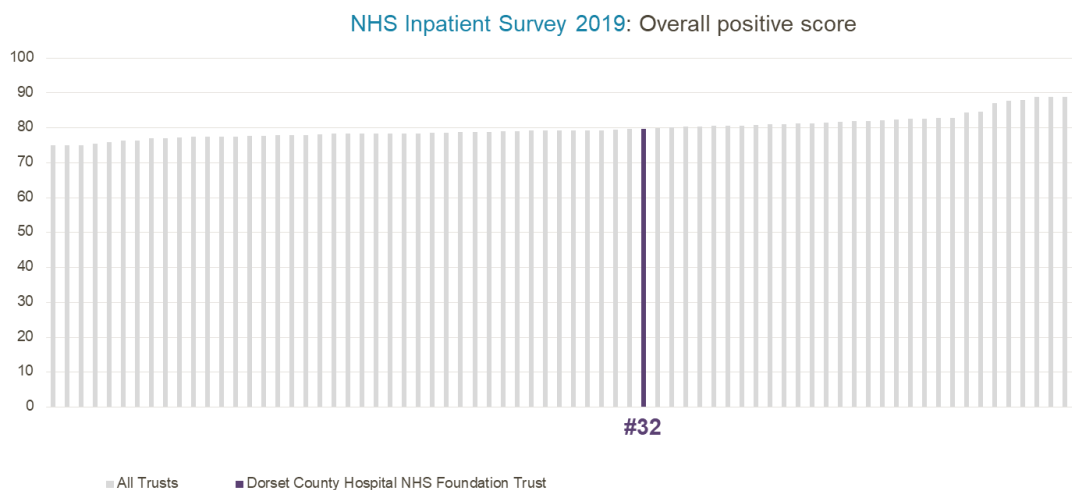
-  Planned admission: was admitted as soon as necessary
-  Planned admission: admission date not changed by hospital
-  Nurses: knew which nurse was in charge of care
-  Overall: asked to give views on quality of care
-  Procedure: told how to expect to feel after operation or procedure

## Our views

**86%** Q68+. Overall: rated experience as 7/10 or more

**98%** Q67. Overall: treated with respect or dignity

**97%** Q24. Doctors: had confidence and trust



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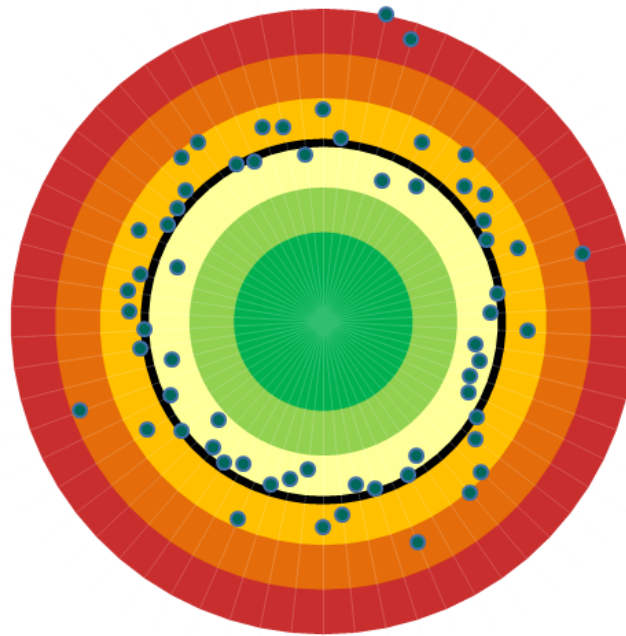
INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE



Dorset County Hospital  
NHS Foundation Trust

Overall development across all questions:

Current scores vs. historical scores



#### KEY



This score is considerably better than the comparison score

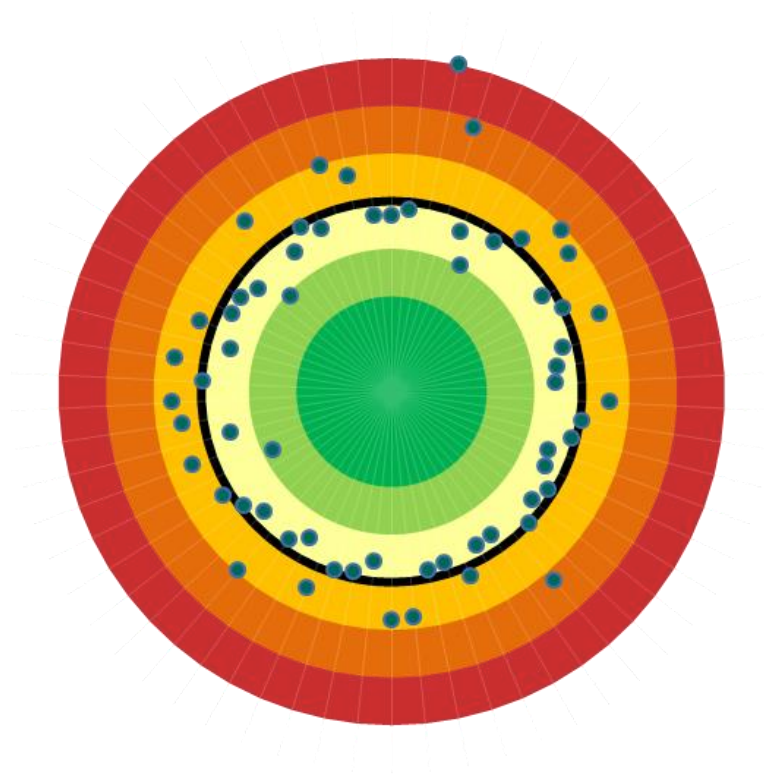


This score is considerably worse than the comparison score

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## Current scores vs. all organisations



### KEY



This score is considerably better than the comparison score



This score is considerably worse than the comparison score

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Improvement Maps™ correlate the results of each question with the overall rating question. Questions are then ranked by the extent that they contribute to patients' overall experience. Results are then compared to DCH performance in comparison to the Picker Average.

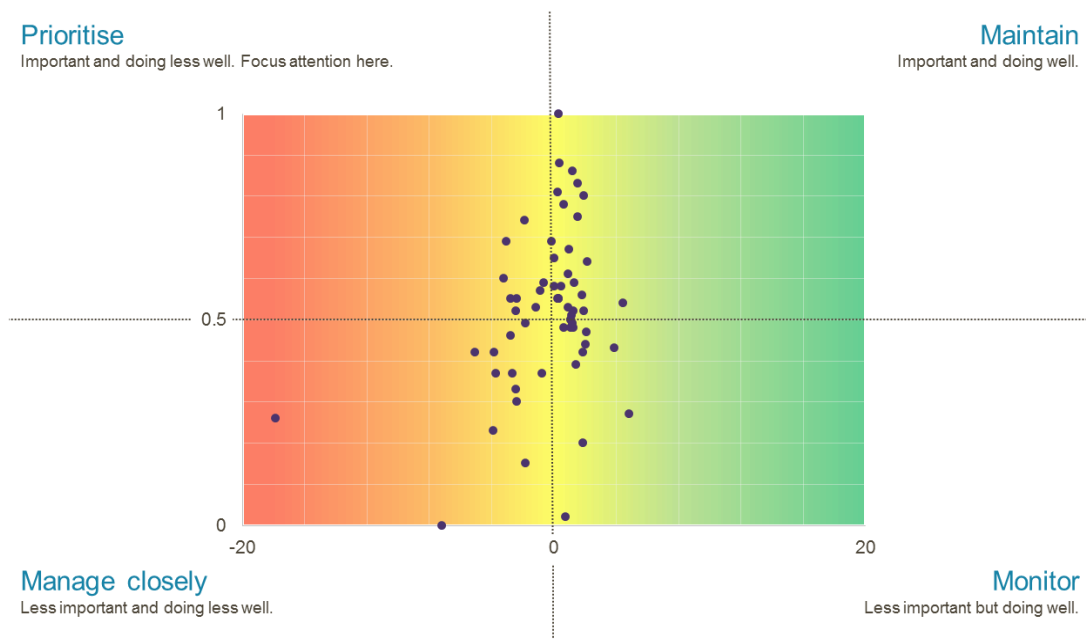
The y (vertical) axis shows the importance of each question to patients' experience; the most important questions appear in the top two quadrants.

The x (horizontal) axis shows our performance in comparison to the Picker Average. Where we have performed better than the Picker Average, questions appear in the right hand quadrants. Where we have performed worse than the Picker Average, questions are plotted in the left hand quadrants.

**PS%** = the positive score shows the percentage of respondents who gave a favourable response to applicable questions.

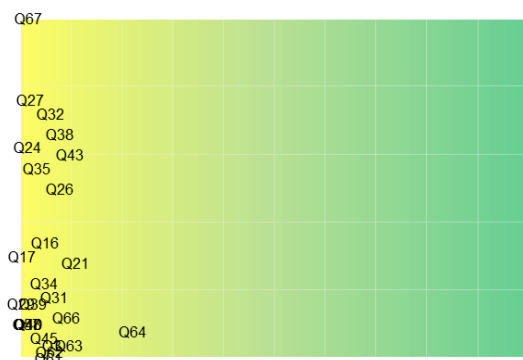
Details of the questions included in each quadrant are on the following pages.

## Overall Improvement Map™



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## Maintain



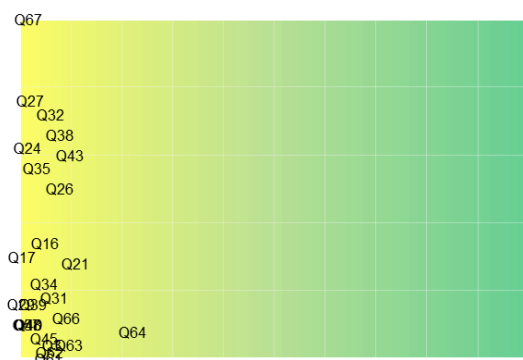
### SUMMARY

Number of questions in this quadrant: 25

Most common theme: [Respect](#), [Emotional](#), [Comfort](#)

Q	Question text	PS%
Q3	A&E Department: right amount of information about treatment or condition	76%
Q16	Hospital: room or ward very or fairly clean	98%
Q17	Hospital: got enough help from staff to wash or keep clean	90%
Q21	Hospital: got enough help from staff to eat meals	85%
Q24	Doctors: had confidence and trust	97%
Q26	Nurses: got clear answers to questions	97%
Q27	Nurses: had confidence and trust	98%
Q29	Nurses: always or nearly always enough on duty	59%
Q31	Other clinical staff: had confidence and trust	97%
Q32	Care: staff worked well together	98%
Q34	Care: was involved as much as wanted in decisions	91%
Q35	Care: had confidence in the decisions made	95%
Q38	Care: enough emotional support from hospital staff	86%
Q39	Care: enough privacy when discussing condition or treatment	95%
Q40	Care: enough privacy when being examined or treated	99%
Q43	Care: staff helped within reasonable time when needed attention	95%

## Maintain



### SUMMARY

Number of questions in this quadrant: 25

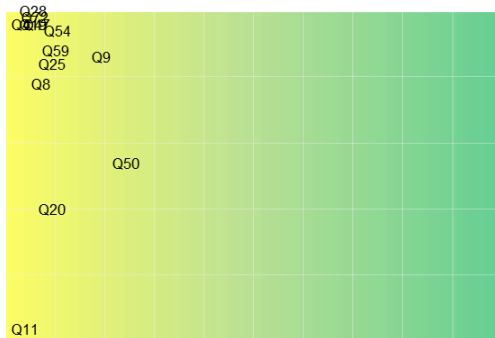
Most common theme: [Respect](#), [Emotional](#), [Comfort](#)

Q	Question text	PS%
Q45	Procedure: questions beforehand answered	98%
Q48	Discharge: felt involved in decisions about discharge from hospital	85%
Q57	Discharge: told purpose of medications	91%
Q61	Discharge: family or home situation considered	83%
Q62	Discharge: family, friends or carers given enough information to help care	77%
Q63	Discharge: told who to contact if worried	78%
Q64	Discharge: staff discussed need for additional equipment or home adaptation	84%
Q66	Discharge: expected care and support were available when needed	83%
Q67	Overall: treated with respect or dignity	98%

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## Monitor



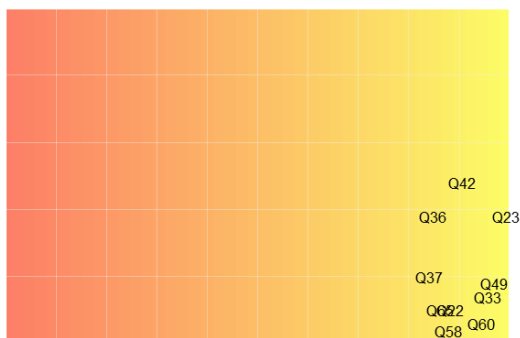
### SUMMARY

Number of questions in this quadrant: 13

Most common theme: [Comfort](#)

Q	Question text	PS%
Q4	A&E Department: given enough privacy when being examined or treated	98%
Q8	Planned admission: specialist given all the necessary information	99%
Q9	Admission: did not have to wait long time to get to bed on ward	66%
Q11	Hospital: did not share sleeping area with opposite sex	92%
Q19	Hospital: food was very good or good	60%
Q20	Hospital: offered a choice of food	96%
Q25	Doctors: not talked in front of patients as if they were not there	80%
Q28	Nurses: not talked in front of patients as if they weren't there	84%
Q47	Procedure: explained how it had gone in an understandable way	93%
Q50	Discharge: was not delayed	65%
Q54	Discharge: got enough support from health or social care professionals	81%
Q59	Discharge: given clear written/printed information about medicines	87%
Q72	Overall: well looked after by non-clinical hospital staff	99%

## Prioritise



### SUMMARY

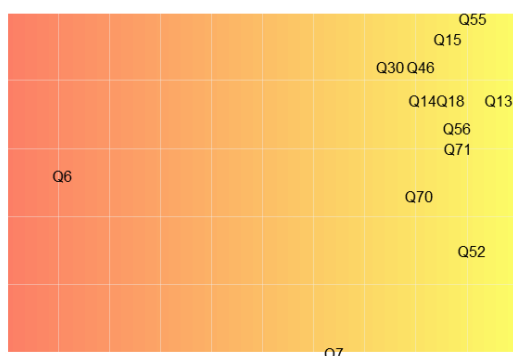
Number of questions in this quadrant: 10

Most common theme: [Transition](#)

Q	Question text	PS%
Q22	Hospital: got enough to drink	89%
Q23	Doctors: got clear answers to questions	95%
Q33	Care: staff did not contradict each other	68%
Q36	Care: right amount of information given on condition or treatment	77%
Q37	Care: found staff member to discuss concerns with	69%
Q42	Care: staff helped control pain	92%
Q49	Discharge: given enough notice about when discharge would be	86%
Q58	Discharge: told side-effects of medications	55%
Q60	Discharge: told of danger signals to look for	63%
Q65	Discharge: staff discussed need for further health or social care services	78%

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## Manage closely



### SUMMARY

Number of questions in this quadrant: 13

Most common theme: [Coordination](#),  
[Information](#)

Q	Question text	PS%
Q6	Planned admission: was admitted as soon as necessary	54%
Q7	Planned admission: admission date not changed by hospital	71%
Q13	Hospital: staff completely explained reasons for changing wards at night	81%
Q14	Hospital: not bothered by noise at night from other patients	59%
Q15	Hospital: not bothered by noise at night from staff	78%
Q18	Hospital: able to take own medication when needed to	77%
Q30	Nurses: knew which nurse was in charge of care	75%
Q46	Procedure: told how to expect to feel after operation or procedure	85%
Q52	Discharge: delayed by no longer than 1 hour	10%
Q55	Discharge: knew what would happen next with care after leaving hospital	82%
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	61%
Q70	Overall: asked to give views on quality of care	10%
Q71	Overall: received information explaining how to complain	17%

## 2. RECOMMENDATIONS:

- Note the contents of this report
- Analysis of patient comments for further detail and themes
- Full triangulation of data with the Staff Survey information
- Compare results with Trusts who perform well in areas in need of improvement
- Develop action plan, to be shared with Patient Experience Group and reported to Quality Committee

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<b>Title of Meeting</b>	<b>Board of Directors' Meeting.</b>
<b>Date of Meeting</b>	<b>26<sup>th</sup> August 2020.</b>
<b>Report Title</b>	<b>Decision Making Outside Formal Board of Director Meetings.</b>
<b>Author</b>	<b>Trevor Hughes, Head of Corporate Governance.</b>
<b>Responsible Executives</b>	<b>Mark Addison, Trust Chair and Patricia Miller Chief Executive.</b>

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

This report outlines the provisions within the Standing Orders to facilitate committee and Board level decision making outside formal meetings and proposes a process for doing so in the rare event that the need arises.

**Summary**

There are rare occasions when the Board or its committees are required to make decisions within a short timescale that does not allow the decision to wait until it can be considered in a formal meeting. This paper outlines the provisions within the agreed Standing orders for making such decisions, benchmarks practice with the other NHS organisations and the wider industry sector and proposes a process for undertaking short notice Board and Committee decision making within the trust should the need arise.

The process proposed is

- Where more than three days' notice of the decision is provided, that an extraordinary meeting of the relevant committee (and Board should this be necessary) will be held to consider and approve the decision;
- Where less than three days' notice of the decision is provided, the Trust Chair and Chief Executive will take the decision on behalf of the committee / Board in consultation with two officer members of the trust.

In both circumstances, the resulting decision will be notified to the respective committee / Board at the next formal meeting.

The Board is asked to approve the arrangements for short notice decision making outside formal Board meetings.

**Paper Previously Reviewed By**

This paper is for the Board of Directors and has been developed in consultation with the Trust Chair and Chief Executive.

**Strategic Impact**

Clarity of process in the event that short notice decisions are required will support considered decision making in an open, transparent and responsive manner.

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<b>Risk Evaluation</b>	
<b>Impact on Care Quality Commission Registration and/or Clinical Quality</b>	
<b>Governance Implications (legal, clinical, equality and diversity or other):</b> The Board of Directors seeks to continue to operate in an open and transparent manner maintaining accountability to the trust's Governors, members and the wider public in line with the requirements placed on organisations operating in the public domain and with foundation trust license conditions.	
<b>Financial Implications</b>	
<b>Freedom of Information Implications – can the report be published?</b>	Yes
<b>Recommendations</b>	To approve the process for short notice decision making outside formal Board of Director meetings.

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## **Decision Making Outside Formal Board of Director Meetings**

### **Introduction**

Two extraordinary meetings of the Finance and Performance Committee and subsequent meetings requiring 'Chairs Action' approval on behalf of the Board were required in June and July 2020 in order to approve investment projects of a value requiring Board approval. Whilst the unusual circumstances and short timescales for decision making were acknowledged and did not allow for prior discussion by the full Board, the Board recognises the need for a formal process to enable such decision making outside formal Board.

This paper outlines national guidance, where this is available, and benchmarking of NHS and wider industry practice in order to make recommendations to the trust regarding the process for urgent decision making should this arise again in the future.

### **DCH Standing Orders**

Dorset County Hospital's Standing Orders form part of the Trust's Constitution and provide for the following in respect to meetings of the Board:

#### **3.1 Calling meetings**

- a. Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Chairman may determine.
- b. The Chairman of the Trust may call a meeting of the Board at any time.
- c. One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

#### **3.2 Notice of Meetings and the Business to be transacted**

- a. Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, or sent by email, so as to be available to members at least 3 clear days before the meeting.

#### **3.3 Agenda and Supporting Papers**

The Agenda will be sent to members a minimum of 5 days (including Saturdays and Sundays) before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

dispatched (electronically or in hard copy) no later than 3 clear days before the meeting, save in emergency.

The current provisions within the Trust's Standing Orders enable meetings of the Board and its committees to be held at short notice (3 days). Calling an extra-ordinary meeting of a committee or the Board in order to make decisions is consistent with the approach outlined within the Standing Orders and promotes the opportunity for open debate and challenge.

### **National Guidance**

'The NHS Foundation Trust Code of Governance' (Monitor July 2014) is silent on the issue of Board decision making on specific operational matters that do not require formal approval of the Council of Governors or notification and approval from the Regulator. NHSI provides further guidance on the role of the provider Chair to promote strategic leadership, openness, transparency and engagement in decision making but does not discuss specific governance protocol in respect to decision making by the Chair on behalf of the Board.

### **Benchmarking - NHS**

There is little published regarding Chair's Action decision making within the NHS. Published examples of Chair's Action include Public Health Wales in September 2019 and Bromley CCG in June 2018, indicating that the need for the NHS to take decisions on this basis is rare and infrequent. Both examples referred to organisational Standing Orders that provided for joint decision making between the Chief Executive and the Chair in consultation with non-officer members of the organisation.

### **Benchmarking - Other Sectors**

The National Governance Association (education) has defined Chair's Action as:

'... the procedure by which the Chair of the Board can take unilateral decisions, bypassing usual processes, in specific circumstances of urgency. Chair's action can be used when the Chair believes a 'delay would be likely to be of serious detrimental to the interests of the organisation'. This emphasises that the bar for justifying Chair's Action is higher than simply any negative consequence of inaction.

### **Most Urgent Decisions**

In the event that a Board level decision is required more urgently and at less than 3 days' notice, the trust's Standing Order provide that:

## 5.2 Emergency Powers and Urgent Decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.6) may in emergency, or for an urgent decision, be exercised jointly by the Chief Executive and the Chairman after having consulted at least two non-officer members (Non-Executive Directors). The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board for formal ratification.

This approach is consistent with the infrequently published examples of Chair's Action having been taken by other NHS bodies.

### Conclusion

The need to take decisions outside of formal Board and committee meetings is a rare occurrence. The DCH Standing Orders provide that meetings of the Board and its committees can be called by the Chair at any time providing at least three days' notice of the meeting. An extraordinary meeting of a committee or the Board in order to make an urgent decision would be the preferred decision making approach as this is consistent with existing governance arrangements within the trust; provided that more than 3 days' notice of the decision has been received and would include the involvement of at least two officer members.

There is also provision within the Trust's Standing Orders for the Chief Executive and Chair to take decisions on behalf of the Board in consultation with two non-officer members of the trust in the event that an urgent decision is required and less than three days' notice has been received.

### Recommendation

1. That an extra ordinary meeting of the appropriate committee of the Board, and the Board itself should this also be required, be called by the Chair in the event that an urgent decision is required by the Board and more than 3 days' notice of the decision has been received.
2. That the Chair and Chief Executive, in consultation with two non-officer members, take any urgent decision on behalf of the Board where less than 3 day's notice of the decision has been received.

**Trevor Hughes**

**Head of Corporate Governance**