**Ref: MA/TH**

**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 **28th July 2020** at **08.30am to 10.50am** in the Boardroom, Vespasian House, Dorchester (Board members) and via Lifesize for presenters/members of the public.

The agenda is as set out below.

Yours sincerely

**Mark Addison**
**Trust Chair**

**AGENDA**

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| **1.** | **Staff Story** | Presentation | | Note | 8.30-8.50 |
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| **2.** | **FORMALITIES** to declare the meeting open. | Verbal | Mark Addison Trust Chair | Note | 8.50-8.55 |
| | a) Apologies for Absence: Nick Johnson, Stephen Slough, Trevor Hughes, James Metcalfe | Verbal | Mark Addison | Note | |
| | b) Conflicts of Interests | Verbal | Mark Addison | Note | |
| | c) Minutes of the Meeting dated 26th May 2021 | Enclosure | Mark Addison | Approve | |
| | d) Matters Arising: Action Log | Enclosure | Mark Addison | Approve | |
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| **3.** | **CEO Update** | Enclosure | Patricia Miller | Note | 8.55-9.10 |
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| **4.** | **COVID-19 Update** | Verbal | Inese Robotham | Note | 9.10-9.20 |
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| **5.** | **Performance Scorecard and Board Sub-Committee Escalation Reports**<br>a) People and Culture Committee<br>b) Quality Committee<br>c) Finance and Performance Committee<br>d) Risk and Audit Committee | Enclosure | Committee Chairs and Executive Leads | Note | 9.20-9.40 |
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| **6.** | **Recovery Framework** | Enclosure | Inese Robotham | Approve | 9.40-10.00 |
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| **Coffee Break 10.00 – 10.15** | | | | | |

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| **7.** | **Medical Revalidation Report** | Enclosure | Alastair Hutchison<br>Julie Doherty | Discuss | 10.15-10.25 |
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| **8.** | **Questions from the Public** | Enclosure | Mark Addison | Note | 10.25-10.40 |
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| | **CONSENT SECTION** | | | | - |
| | The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion. | | | | |
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| **9.** | **Maternity Safety Report** (from Quality Committee) | Enclosure | Nicky Lucey | Note | |
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| **10.** | **CNST Submission** | Enclosure | Nicky Lucey | Ratify | |
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| **11.** | **Quality Account** | Enclosure | Nicky Lucey | Ratify | |
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| **12.** | **Any Other Business** | | | | |
| | Board Meetings Future Format | Verbal | Mark Addison | Note | 10.40-10.50 |
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| **13.** | **Date and Time of Next Meeting** | | | | |
| | The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 25 September 2021** at Vespasian House TBC. | | | | |

**Minutes of a Meeting of the Board of Directors of Dorset County NHS Foundation Trust Held at 08.30am on 26th May 2021 via MS Teams.**

| **Present:** | | |
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| Mark Addison | MA | Trust Chair *(Chair)* |
| Paul Goddard | PG | Chief Financial Officer |
| Judy Gillow | JG | Non-Executive Director |
| Dawn Harvey | DH | Chief People Officer |
| Alastair Hutchison | AH | Chief Medical Officer |
| Nick Johnson | NJ | Deputy Chief Executive |
| Nicky Lucey | NL | Chief Nursing Officer |
| Ian Metcalfe | IM | Non-Executive Director |
| Patricia Miller | PM | Chief Executive Officer |
| Inese Robotham | IR | Chief Operating Officer |
| Stephen Slough | SS | Chief Information Officer |
| Stephen Tilton | ST | Non-Executive Director |
| David Underwood | DU | Non-Executive Director |
| **In Attendance:** | | |
| Rachel Cookson | RC | Matron, Family and Surgical Services Division – Patient Story *(item BoD21/001)* |
| Ciara Darly | CD | Service Improvement Programme Manager *(Item BoD21/010)* |
| Trevor Hughes | TH | Head of Corporate Governance *(Minutes)* |
| Kyle Mitchell | KM | Consultant *(item BoD21/012)* |
| Simon Pearson | SP | Head of Charity and Social Value *(Item BoD21/011)* |
| Natalie Violet | NV | Corporate Business Manager |
| **Members of the Public:** | | |
| Mike Byatt | MB | Governor |
| Kathryn Harrison | KH | Governor |
| Maurice Perks | MP | Governor |

| **BoD21/001** | **PATIENT STORY** | **Action** |
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| | RC presented a video of Andrea's story that recounted her experience of using services at the Trust. Andrea had waited a long time to be seen following referral to the hospital and had been seen by a visiting consultant. Andrea was unhappy with consultation and treatment she had received and did not feel she had been listened to and that her contribution to the consultation had been dismissed. As a result, Andrea had been extremely upset and had lost trust in hospitals and doctors. She believed that patients knew more about their bodies and experience of their symptoms than doctors and that this should be fully considered in consultations. A nurse had observed Andrea was upset as she left the hospital and supported her in returning to the department in order discuss the concerns Andrea had.<br><br>Andrea was keen to ensure that learning could be taken from her experience and agreed to make a video for education and training purposes which is now being widely used within the Trust and | |

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| | volunteers regularly.<br><br>Andrea's message emphasised that patients were not merely a number or a ten minute time slot and that clinicians should acknowledge when patients became increasingly distressed and respond accordingly. A holistic view of patients should also be considered and consultations should not focus only on the medical condition.<br><br>The Board thanked RC for the video and extended their thanks to Andrea for telling her story. The contribution of the nurse was acknowledged and the positive eventual outcome for Andrea and the Trust through the production of the educational video and volunteering was noted.<br><br>The Board acknowledged that patient interactions required compassion and that listening to patients was a skill. The developing People Plan would need to consider how people were skilled and the culture developed to ensure compassionate and outstanding care. Additionally, further consideration would be given to governance arrangements when working with teams from outside the Trust to ensure that individuals were held to account and that patients received a positive experience of the Trust. The Board noted that complaints received were shared with the individuals in order that they are able to reflect on their behaviours.<br><br>MA thanked RC for the sobering account and noted the positive manner in which the story was being used to follow through with individuals and the organisation. MA noted links to wider organisational development and culture work and further consideration was being given to making 'listening' training mandatory. The Trust's response to the story had been positive and MA undertook to write to Andrea to thank her for her story and for continuing to support the hospital through her volunteering work. | **MA** |
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| **BoD21/002** | **FORMALITIES** | |
| | The Chair declared the meeting open and quorate. He welcomed DH, Chief People Officer and Governor members of the public to the meeting. MA noted that questions from the public could be raised at the end of the meeting.<br><br>Apologies for absence were received from Richard Sim and Sue Atkinson. | |
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| **BoD21/003** | **Declarations of Interest** | |
| | There were no conflicts of interest declared in the business to be transacted on the Agenda. | |
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| **BoD21/004** | **Minutes of the Meeting held on the 31st March 2021** | |

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| | Members of the Board considered the Minutes of the minutes of the meeting held on 31st March 2021 which were agreed as an accurate record of the meeting. | |
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| | **Resolved: that the Minutes of the meeting held on 31st March 20921 were and approved.** | |
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| **BoD21/005** | **Matters Arising: Action Log** | |
| | The Action Log was considered and updates were noted. Approval was given for the removal of completed items. There were no other matters arising. | |
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| | **Resolved: that updates to the Action Log be noted with approval given for the removal of completed items.** | |
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| **BoD21/006** | **CEO Update** | |
| | PM highlighted the following key items for further discussion:<br><br>DCH had submitted an operating plan for H1 in line with NHSE/I operating plan guidance. Going forward the Trust had to focus on a number of operational priorities:<br>• Improve operational performance across all areas and return to business as usual. Improvement plans and trajectories were in development and would be reviewed by committees the following month;<br>• Maximise availability of Elective Recovery Funds in order to reduce the waiting lists equitably;<br>• Review investments and, where business cases had not been supported by the system, in the context of the Trust's appetite for risk;<br>• Implement a new workforce planning structure and development of a greater understanding of the workforce gaps;<br>• Progress the Equality, Diversity and Inclusion Strategy and consolidate long term behaviours.<br><br>As the Trust Strategy review had now reached its conclusion there were a number of enabling strategies required to support the delivery of the corporate strategy:<br>• Clinical<br>• People<br>• Digital<br>• Long term finance<br><br>Once these were complete an integrated strategic plan would be created .The enabling strategies would be presented to the Board in October. A review of the long term financial plan would be undertaken following the comprehensive spending review in order | |

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| | to better understand the underlying deficit position of the Trust and determine how best to address this. The expectation was that the underlying deficit would fall into three categories:<br>• Areas of overspend that DCH could reduce through increased efficiency;<br>• Areas of overspend that were structural;<br>• Areas of overspend that could be reduced through improved system working and collaboration.<br><br>Other developments included the launch of the LGBTQ+ and Disability and Long Term Conditions Networks with consideration being given to the development of a Carers Network.<br><br>The Vaccination Hub had closed and thanks were extended to the leadership and teams for their additional commitments to delivering the very successful programme.<br><br>Two consultant Opthalmologists had been appointed and would help to address long waiting times within the service.<br><br>The positive outcomes of recent external reviews were noted: in particular the education quality review undertaken by Health Education England and the annual decontamination service review.<br><br>The use of 12 month trend analyses was being considered in order to more closely monitor deterioration in performance and ensure corrective action was taken before an operational standard was missed.<br><br>In terms of the Corporate Strategy, it was important that the enabling strategies were now developed, namely the clinical Strategy, People Plan and Digital Strategy. A multi professional engagement approach had been agreed for this work with the aim of conclusion at the end of September. | |
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| | **Resolved: that the CEO Update be received and noted.** | |
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| **BoD21/007** | **COVID-19 Update** | |
| | IR reported that DCH had one COVID positive inpatient that did not require ITU care. The Incident Management Team continued to meet on a weekly basis. There were no issues with PPE or oxygen supplies.<br><br>IR reminded that COVID safety arrangements continued to be operated as services returned to business as usual and that these contributed to service inefficiencies. The COVID position locally continued to be reported nationally. | |
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| | **Resolved: that the COVID-19 Update be noted.** | |

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| **BoD21/008** | **Performance Scorecard and Board Sub-Committee March Escalation Reports** | |
| | The Non-Executive Chairs of the following committees provided feedback from committee meetings held the previous week, noting:<br><br>**People and Culture Committee**<br>The positive feedback received from Health Education England following their recent review;<br>The Equality, Diversity and Inclusion Strategy would be presented to the Board later in the year. An interim framework and Action Plan was being delivered and monitored by the committee.<br><br>**Quality Committee**<br>Continued concerns regarding capacity of the Stroke Unit due to delays in discharges;<br>The national lack of Tier 4 mental health provision and implications for the placements for young people locally were of concern;<br>The recently completed review of reportable pressure ulcers had indicated an overall positive position with the Trust remaining within the trajectory. Work to improve data quality and strengthen quality improvement measures was underway;<br>There was recognition that whilst the Trust was under the trajectory for Clostridium Difficile and Methicillin Sensitive Staphylococcus Aurea infections and no lapses in care had been identified, cases were increasing across Dorset; possibly as a result of increased antibiotic prescribing due the COVID. The outcome of a system-wide review was awaited.<br><br>**Finance and Performance Committee**<br>The number of patients in hospital with 'no reason to reside' had doubled during the previous week;<br>The changing profile of the waiting list noted a higher proportion of people waiting over 52 weeks, despite a significant reduction in the number of over 52 week waiters having been realised since February 2021. The need to consider additional Elective Recovery Funding and address long waiting times equitably was noted;<br>Further discussion of the recovery programme and investment project risks was scheduled for Part 2 of the meeting.<br><br>**Risk and Audit Committee**<br>The Annual Report and Accounts would be subject to further discussion in Part 2 of the meeting;<br>Limited assurance had been received on the clinical validation of the waiting list audit and a plan to deliver actions identified by the end of August was in place;<br>Moderate assurance had been received via the Head of Internal Opinion on the Trust's overall systems of internal control;<br>Inequalities would be incorporated as a key component of future | |

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| | Internal Audits and a new one page summary of audits would be reviewed by the Risk and Audit Committee at their next meeting; Governor observing the meeting had previously questioned the need to include the digital risk within the Corporate Risk Register and this was being given further consideration.<br><br>SS joined the meeting. | |
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| | **Resolved that: the Performance Scorecard and Board Sub-Committee March Escalation Reports be received and noted.** | |
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| **BoD21/009** | **Recovery Overview** | |
| | NJ provided a brief update on progress of the Recovery Framework that had been approved by the Board in March and which now formed part of the daily operations of the Trust. Key elements were being reported via existing governance committees and the report triangulated these for the Board.<br><br>NJ noted further work to develop and agree improvement trajectories with the Senior Management Team (SMT) and proposed that the framework be developed and returned to the Board and committees following the next SMT meeting. The timetable for performance reporting and development of a redesigned score card was to be agreed following further executive discussion. | **NJ** |
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| | **Resolved that: the Board would revisit the Recovery Overview after further executive discussion.** | |
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| **BoD21/010** | **Draft Strategy** | |
| | CD joined the meeting.<br><br>NJ noted broad consultation and engagement during the development of DCHFT Strategy and sought Board approval of the same. He advised that a shortened version of the document would be developed for communication into the organisation and that no significant changes had been made since previous discussion by the Board. The core Strategic Objectives remained 'People, Place and Partnership'.<br><br>The Board welcomed the more focussed approach provided within the document and noted and welcomed the extensive consultation and discussion of previous versions. The Board noted in its earlier discussion it had agreed that the focus of the People objective should be on staff, ensuring that they felt valued by the Trust, and the Place objective on local community needs. Clearer distinction within the document would be of benefit there as well increased emphasis vertical (especially) and horizontal integration and joint working / partnering arrangements with local authorities and how | |

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| | success might be measured.<br><br>The work to develop the strategy, given the constraining factors of COVID, was acknowledged.<br><br>KM joined the meeting.<br><br>The Board noted the planned development of the enabling strategies and the performance scorecard and the strategy was approved subject to the points made in discussion..<br><br>CD left the meeting. | |
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| | **Resolved that: the DCHFT Strategy be approved.** | |
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| **BoD21/011** | **Social Value Action Plan** | |
| | NJ provided an overview of progress to date with the DCH Social Value programme. SP joined the meeting and recalled prior approval by the Board of the Social Value Pledge in November 2020 and the request for six monthly updates on progress. SP advised that a Social Value progress dashboard was in development and that a Social Value Impact Assessment had been developed.<br><br>The Multi-Storey Car park development was delivering £4m local social value investment and the Kick Start programme provided a further tangible example of the Trust's commitment to providing social value locally.<br><br>Progress in delivering the Social Value Action Plan had been made despite the impact of COVID, consideration would now be given to the best approach to introducing the action plan to teams across the Trust, with consideration to adopting an organisational development approach to achieve this. Strengthening the role of Governors within the 'Involving the Community' work stream would be discussed at the next meeting of the Social Value Programme Group and the theme of the Open Day (COVID restrictions permitting) could be focussed on social value and include the Trust's membership. The need to establish local media relations that would promote local communications about DCH social value programme opportunities was noted.<br><br>MA acknowledged the breadth of the programme and the comprehensive and ambitious objectives within the action plan. He enquired how the programme integrated with other planning objectives. Key social value elements would be included in future strategic measures within social value dashboard and impact assessments would be considered across areas of service and policy change. The suite of integrated enabling strategies would | |

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| | also include social value measures going forward.<br><br>The social value progress update was noted and the action plan was approved.<br><br>SP left the meeting. | |
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| | **Resolved that: the Social Value Action Plan be approved.** | |
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| **BoD21/012** | **Guardian of Safe Working Report** | |
| | KM joined the meeting for this item and highlighted the invaluable contribution made by junior doctors over the previous year; noting the often difficult social circumstances under which they worked and impact of the pandemic on training programmes.<br><br>KM recognised the work undertaken by the Trust to promote safer working that had resulted in a reduced number of exception reports being raised by staff and increased numbers of junior doctors, providing service resilience at a difficult time. KM reported that junior doctors felt able to raise concerns and that the Trust's response had been positive, resulting in staff feeling supported.<br><br>KM reported that there had been a reduction in career and international training and development opportunities during the pandemic for junior doctors and that this had aided staff retention rates. He urged caution as restrictions were lifted globally, noting that approximately 25% of doctors took international training opportunities and that this would need to be considered as part of the longer term strategy.<br><br>The Board thanked KM for his report and his passion and commitment to the role. | |
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| | **Resolved that: the Guardian of Safe Working Report be noted.** | |
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| **BoD21/013** | **Board Sub-Committees:**<br>• **Effectiveness Reviews**<br>• **Terms of Reference**<br>• **Priorities**<br>• **Cycles of Business** | |
| | MA summarised the papers submitted, noting the planned development of committee priorities for the People and Culture Committee with a view to submission to the Board in June 2021. The Board noted the identification of areas of shared working and the refreshed approach within committee Terms of Reference to the management of risks and broader application of the trust's risk appetite. | |
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| | **Resolved that: the** | |

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| | • **Committee Effectiveness Reviews be noted;**<br>• **Terms of Reference be approved;**<br>• **Committee Priorities be approved;**<br>• **Cycles of Business be approved.** | |
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| | **CONSENT SECTION** | |
| | The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting. | |
| **BoD21/014** | **Annual Statutory Declarations** | |
| | PG clarified that continued uncertainty in respect of H2 financing had resulted in a qualified declaration regarding the availability of resources to meet the Trust's planned obligations, noting also the underlying deficit position.<br><br>The declarations were approved. | |
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| | **Resolved that: the Annual Statutory Declarations be approved and published.** | |
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| **BoD21/015** | **NED Committee Membership Proposal** | |
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| | **Resolved that: the NED Committee Membership Proposal be approved.** | |
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| **BoD21/016** | **Safeguarding Annual Report** | |
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| | **Resolved that: the Safeguarding Annual Report be noted.** | |
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| **BoD21/017** | **Corporate Risk Register** | |
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| | **Resolved that: the Corporate Risk Register be noted.** | |
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| **BoD21/018** | **Board Assurance Framework** | |
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| | **Resolved that: the Board Assurance Framework be noted.** | |
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| **BoD21/019** | **Communications Report October 2020 to March 2021** | |
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| | **Resolved that: the Communications Report October 2020 to March 2021 be noted.** | |
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| **BoD21/020** | **Questions from the Public** | |
| | MP commented on his membership of wider digital group and the potential for continued central support to deliver the digital agenda within the NHS. He welcomed the planned suite of enabling strategies that would return to the Board in October.<br><br>SS noted the greater use of digital technologies and the ED 15 | |

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| | programme that would develop this aspect further. He welcomed any potential further national support.<br><br>PM left the meeting. | |
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| | **Resolved that: discussion of the Questions from the Public be noted.** | |
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| **BoD21/021** | **Any Other Business** | |
| | IM advised that he had decided to step down from his commitments with the Trust at the end of the year for personal reasons. The Chair said that Ian would be much missed but the Board understood. There would be an occasion to thank Ian more formally at the appropriate time. | |
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| **BoD21/022** | **Date and Time of Next Meeting** | |
| | The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 28th July 2021** Venue / Mode of operation TBC | |

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**Signed by Chair …….. Date ……..**

**Action Log – Board of Directors Part 1**

**Presented on: 28th July 2021**

| Minute | Item | Action | Owner | Timescale | Outcome | Remove ? Y/N |
|---|---|---|---|---|---|---|
| **Meeting Dated: 26th May 2021** | | | | | | |
| **BoD21/001** | **PATIENT STORY** | A letter of thanks to be sent to Andrea on behalf of the Board for telling her story to the Board. | **MA** | **June 2021** | Letter sent | Yes |
| **BoD21/009** | **Recovery Overview** | The framework report and improvement trajectories to be returned to committees and the Board following further development and agreement with the Senior Management Team and discussion by the Executive team. The timetable for performance reporting and development of the scorecard is also to be agreed. | **NJ** | **TBA** | | |
| **Actions from Committees…(Include Date)** | | | | | | |
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| **Meeting Title:** | Board of Directors |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | **Chief Executive's Report** |
| **Responsible Director:** | Patricia Miller, Chief Executive |
| **Author:** | Natalie Violet, Corporate Business Manager to the CEO |

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| **Confidentiality:** | The document is not confidential |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
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| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Chief Executive | 21 July 2021 | Approved |

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| **Purpose of the Paper** | For information. | | | | | | | |
| | *Note* | ✓ | *Discuss* | | *Recommend* | | *Approve* | |
| **Summary of Key Issues** | This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also included reflections on how the Trust is performing and the key areas of focus.<br><br>The key developments nationally are as follows:<br><br>• On its 73rd Birthday the NHS was awarded the George Cross for 73 years of dedicated service and the response to the COVID-19 pandemic by Her Majesty the Queen.<br>• Sajid Javid replaced Matt Hancock as Secretary of State for Health and Social Care<br>• The Government published the Health and Care Bill building on the legislative changes outlined in the NHS Long Term Plan and lessons learned from the pandemic.<br>• NHS England and NHS Improvement announced the Elective Recovery Fund threshold has increased from 85% to 95% from 01 July 2021.<br>• The easing of lockdown restrictions in England commenced on 19 July 2021, removing all legal restrictions on social contact and face coverings. There will be no change to coronavirus guidelines within healthcare settings and therefore all patients, staff, and visitors must continue to wear face coverings, unless exempt, and follow social distancing measures and visiting guidance.<br>• A third booster dose of the COVID vaccination will be provided for those most vulnerable from September 2021 at the same time as an expanded flu vaccination programme.<br><br>Locally the biggest concern lies with emergency demand, as the hospital continues to experience a sustained increase in non-COVID emergency demand, with all parts of the system remaining under considerable pressure both in terms of levels of front door demand and packages of care. It is becoming increasingly concerning regarding our ability to keep patients and staff safe and maintain resilience within teams, given the challenging circumstances. Bed occupancy levels across Dorset are very high in all hospitals with very little flexibility and the South West Ambulance Service are experiencing record numbers of calls and conveyances. There is a potential risk of declaring a major incident during the summer holidays and we need to ensure we are doing our upmost to prevent this. Regular system-wide executive level meetings are now taking place to work in partnership to support our teams. | | | | | | | |

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| **Action recommended** | The Board of Directors is recommended to:<br><br>1. **NOTE** the information provided. |

**Governance and Compliance Obligations**

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| **Legal / Regulatory** | Y | Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation. |
| **Financial** | Y | Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability. |
| **Impacts Strategic Objectives?** | Y | For the Board to operate successfully, it must understand the wider strategic and political context. |
| **Risk?** | Y | Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.<br><br>The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed. |
| **Decision to be made?** | N | No decision required; this report is for information. |
| **Impacts CQC Standards?** | Y | An understanding of the strategic context is a key feature in strategy development and the Well Led domain.<br><br>Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators. |
| **Impacts Social Value ambitions?** | N | No impact on social value ambitions |
| **Equality Impact Assessment?** | N | EIA not required; this report is for information |
| **Quality Impact Assessment?** | N | QIA not required; this report is for information |

**Chief Executives Report – July 2021**

**Strategic Update**

**National Perspective**

**Secretary of State for Health and Social Care**
At the end of June Sajid Javid returned to government replacing Matt Hancock as Secretary of State for Health and Social Care with his priorities including navigating the next phase of the COVID-19 pandemic and associated backlogs of care plus the new legislation to reorganise the NHS.

**NHS England Chief Executive**
The recruitment process to replace current NHS England Chief Executive, Lord Simon Stevens, is currently underway with final formal interviews due to take place towards the end of July with four candidates: KPMG partner Mark Britnell, former Amazon UK Chief Douglas Gurr, NHS Deputy Chief Executive Amanda Pritchard, and Leeds City Council Chief Executive Tom Riordan.

**NHS Awarded the George Cross**
The NHS turned 73 on the 05 July 2021 and saw the announcement of the NHS being awarded the George Cross for 73 years of dedicated service and the response to the COVID-19 pandemic by Her Majesty the Queen. For the Queen to dedicate the George Cross to the NHS demonstrates the enormous challenge faced by all staff in dealing with the COVID-19 pandemic and this is a well-deserved recognition for generations of health service staff. I was also able to join colleagues from local partner organisations at a ceremony on this date to celebrate the birthday, to thank all key workers for their contribution over the last year and remember those who lost their lives.

**Local Relevance**

**Health and Social Care Bill**
On 06 July 2021, the Government published the Health and Care Bill building on the legislative changes outlined in the NHS Long Term Plan and lessons learned from the pandemic. With the intention to create a system that is more accountable and responsive to both staff and communities. The principle focus of the legislation is to remove barriers to collaboration and therefore support greater levels of integration.

There are several key elements to the legislation:

- CCGs will be abolished, and commissioning functions will be integrated into ICSs.
- Specialist commissioning functions will be delegated from NHS England Regional Teams and into ICSs.
- NHS England and NHS Improvement will merge.
- It increases the powers of the Secretary of State for Health and Social Care over the NHS, these were previously diluted in the 2012 Care Act.
- ICS will be expected, through a system oversight framework, to implement an assurance process that will oversee the quality and safety of services provided. However, the provider accountability framework is not going to significantly change therefore clarification of how the two will work together to best effect is required.
- It changes the arrangements for capital allocations for Foundation Trusts following the difficulties the Department of Health and Social Care have previously faced in controlling capital spend to within the capital department resource limits (CDEL).
- It requires the creation of and ICS NHS body and subsequent Board.
- It requires the creation of Health and Care Forum/ICS Partnership.

The DCH Executive Team continue to work with system partners in the design and development of the new Dorset ICS.

**BMA Medical Staffing Report**
In July, the British Medical Association (BMA) published a report on medical staffing in England illustrating the severe medical shortages facing the healthcare system. The recommendations in the report ask for regular healthcare workforce assessments to be mandated in the Health and Care Bill and increased treasury investment in the medical workforce to ensure:

- Sufficient medical school, foundation programme and specialty training places.
- Expansion of teaching spaces and student clinical placement options.
- Rapid expansion of the medical education and research, public health consultant and specialist occupational physician workforce.
- A relaxation of pension taxation rules and introduction of flexible working options for all staff.
- Doctor retention initiatives across all grades of doctor.

This month the Government commissioned Health Education England to review long term strategic trends for the health and social care workforce. This will review and update the existing long term strategic framework for the health workforce and for the first time it will include registered professionals working in social care. The framework will be a reference point and guide decisions on how the NHS and social care approaches problems and identifies solutions in the short, medium, and long term.

Locally, we are ensuring our refreshed People Plan reflects the aspirations of the NHS People Plan which recommends recruitment across the workforce, reversing the trend of early retirement, maximising on opportunities created by the COVID-19 pandemic, retaining people, and refreshing talent pipelines.

**Zero Carbon Footprint**
NHS England have confirmed they will publish each Integrated Care System's (ICS) baseline carbon footprints by 30 September 2021 to track progress against the sustainability programme. It is expected Trust footprints will be developed following this. NHSE's Greener NHS National Programme team will be responsible for calculating each ICS and Trust's figures using local data which will be submitted quarterly.

On 29 June 2021 I joined a South West regional environmental sustainability workshop. As the lead for health inequalities across the Dorset ICS I am also responsible for making sure we have a plan to meet the net zero carbon target the NHS has set itself. During the workshop I gave a presentation on how we are approaching this in Dorset. This included all partners committing to reducing inequalities and improving the overall wellbeing of our local communities, the creation of an ICS Anchor Institutions Network, the development of an Our Dorset Social Value Vision and Pledge and working together towards the Greener NHS net-zero objectives committing to protecting the environment, minimising waste, water, and energy consumption and using other resources efficiently within our organisations and supply chains.

**Elective Recovery Fund**
This month NHS England and NHS Improvement announced the Elective Recovery Fund threshold has increased from 85% to 95% from 01 July 2021. Trusts will now be required to operate at 95% of pre-COVID activity levels, compared to 2019/20, to access money from the fund designed to aid reduction in backlogs. Nationally organisations have been performing better than expected, as we head into summer activity numbers will decline and if COVID-19 demand increases planned care will be reduced to manage this. On a local level ERF is awarded to systems and we are currently working with our system partners to establish the impact of this change.

**Easing Lockdown Restrictions - 19 July 2021**
On 19 July 2021 we saw the easing of lockdown restrictions in England removing all legal restrictions on social contact and face coverings. There will be no change to coronavirus guidelines within healthcare settings and therefore all patients, staff, and visitors must continue to wear face coverings, unless exempt, and follow social distancing measures and visiting guidance. The easing of restrictions

has the potential for COVID-19 cases to rise and therefore the pressure on the NHS will increase which may hinder abilities to reduce the current waiting list backlogs.

**Self-Isolation**
With the number of infections increasing to the same levels of January 2021, the beginning of July saw a significant increase in people being advised to self-isolate by the NHS Test and Trace app. Unfortunately, Trusts are seeing an impact of their ability to deliver patient care due to staff required to isolate although the Government are considering exempting front line staff from isolation requirements. DCH has experienced a small number of staff having to isolate due to test and trace, single numbers. Self-isolation rules are expected to be lifted on 16 August 2021 and replaced by a lighter testing regime for anyone who has received both vaccination doses.

**COVID Boosters and Flu Vaccinations**
A third booster dose of the COVID vaccination will be provided for those most vulnerable from September 2021 at the same time as an expanded flu vaccination programme. The Joint Committee on Vaccination and Immunisation (JCVI) have advised boosters should be offered to those most clinically vulnerable first starting with adults aged 16 and over who are immunosuppressed or clinically extremely vulnerable, residents in care homes for older adults, all adults aged 70 and over and frontline health and social care workers. Following these groups all adults aged 50 and over, adults agreed 16-49 who are in flu or COVID-19 at-risk groups and those living in the same house as people who are immunosuppressed. We are currently working with system partners and are looking to reopen the on-site vaccination hub to provide both vaccinations.

It is expected the Government will shortly start consulting on mandatory COVID-19 vaccination for all patient facing health and social care staff.

**Funding for Ambulance Trusts**
On 14 July 2021 NHS England announced an additional £55 million will be provided to boost ambulance Trust staffing numbers ahead of winter with the aim to recruit more 999 call handlers, crews and clinicians to work in control rooms, and liaison offers to manage the handover of patients between ambulances and hospitals.

**Race and Health Observatory Board**
The Race and Health Observatory Board met on 15 July 2021. The agenda focussed on the strategy and work programme along with communications and media. There were also two papers looking at maternal health and how equity of outcomes can be achieved and how inequalities in diagnosis, treatment and outcomes can be reduced in mental health services. The Observatory have launched a survey, which closes on 10 August 2021, for stakeholder and communities to engage over preferred terminology describing ethnic identity with the aim to seek stakeholder views on the collective terminology used to describe Black, Asian, and other minority ethnic groups, moving away from initialisms and acronyms.

**South West Disability Summit**
On 23 June 2021, in my capacity as EDI lead for the SW region, I attended the South West Disability Summit along with our Disability and Long Term Health Conditions Network Lead. The summit focused on the importance of lived experiences, bringing your whole self to work, the Learning Disability Employment Programme (LDEP) and the Workforce Disability Equality Standard (WDES). The learning from the summit will be incorporated into our network workplan to improve experiences at DCH.

**National People Board**
At the end of June, I joined the NHS Nation People Board, the discussions focused on how we provide an environment where all our NHS people feel a sense of belonging when at work. I was asked to share the work DCH is undertaking in relation to EDI and the Board would like to look at this in more detail to possibly inform national policy and the concept of exemplar sites

**HSJ Top 50 CEO Roundtable**
In June I participated in a roundtable with the HSJ following the publication of their top 50 Chief Executives to discuss the personal and organisational impact of the COVID-19 pandemic. As a result, the HSJ published a guide in July. The areas covered included reimagining the NHS post COVID, the personal impact of the pandemic and building and sustaining radically human organisations. It was privilege to be asked to participate and listen to the experiences of my CEO colleagues across the country.

**Dorset Integrated Care System**
The system has a programme management structure in place with several workstreams looking at the various aspects. A paper outlining the proposed ICS NHS Board formation will be presented at the System Partnership Board at the end of this month for comments. Recruitment for key appointments is underway with the expectation of Chairs and CEOs being appointed during Q2 followed by Non-Executive Directors and ICS NHS Board Executives during Q3.

**DCH Performance**

**Emergency Demand**
The hospital continues to experience a sustained increase in non-COVID emergency demand, with all parts of the system remaining under considerable pressure both in terms of levels of front door demand and packages of care. It is becoming increasingly concerning regarding our ability to keep patients and staff safe and maintain resilience within teams, given the challenging circumstances. Bed occupancy levels across Dorset are very high in all hospitals with very little flexibility and the South West Ambulance Service are experiencing record numbers of calls and conveyances. There is a potential risk of declaring a major incident during the summer holidays and we need to ensure we are doing our upmost to prevent this. Regular system-wide executive level meetings are now taking place to work in partnership to support our teams.

**Inclusive Leadership Programme**
June saw the start of our Inclusive Leadership Programme with 80 people from across our middle and senior leadership teams completing the first session. I was very pleased to see the high level of engagement from participants. The session included the role of social identity and how it shapes our view of the world and lived experience along with the difference in life chances, health, and wealth linked to identity. The feedback received from the programme was positive and very thought-provoking, although at times uncomfortable which is to be expected when challenging assumptions and bias. The programme continues with a further five sessions and the Organisational Development Team are planning a further four cohorts to commence from September.

In my role as lead for ED&I for the South West Region we have commissioned an Inclusive Leadership Programme for Chief Executives across the South West, an introductory session took place in July with the first session is being planned for September.

**New Hospital Programme**
In June, the organisation had an external deep dive into our New Hospital Project, to build a new Emergency Department, Intensive Care Unit, and Integrated Hub. We received positive feedback on the progress we are making to complete and submit the Outline Business Case by autumn. Since the deep dive we have received confirmation, subject to submitting a robust affordable business case, we have been moved into the first phase of the national New Hospital Programme and are expecting to deliver our new facilities around 2025/26.

**Dorset Innovation Hub**
The Dorset Innovation Hub was named as one of four hubs across the country to be award Health Foundation funding following a competitive process. The funding will support the hub to be established and developed in Dorset, providing expertise and help build knowledge, skills, and confidence in identifying and adopting innovations.

**New Digital Maternity System**
Our new digital maternity system, BadgerNet, went live in July allowing the maternity team to collect quality data and allow improved reporting. This is a collaborative pan-Dorset project with UHD who will be going live with BadgerNet from October 2021.

**Senior Management Team Meeting**
We have made some important changes to the role and function of our SMT. Firstly we have changed the name to the Senior Leadership Group (SLG) to represent the roles in terms of leadership which is very different to management. We have amended the Terms of Reference to enhance its remit and responsibility devolving all operational decisions to this group, recognising the importance of growing our leaders and demonstrating trust in them to make the right decisions. This will also allow the Executives to have more time to operate at a strategic level and engage further in the development of the new Dorset Integrated Care System.

| | |
|---|---|
| **Meeting Title:** | **Board of Directors Part One** |
| **Date of Meeting:** | **28 July 2021** |
| **Document Title:** | **Performance Scorecard and Board Sub-Committee Escalation Reports** |
| **Responsible Director:** | **Executive Team** |
| **Author:** | **Liz Beardsall, Deputy Trust Secretary** |

| | |
|---|---|
| **Confidentiality:** | No |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Finance and Performance Committee (performance metrics) | 21 July 2021 | See committee escalations |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors. | | | | | | | |
| | *Note (✓)* | ✓ | *Discuss (✓)* | ✓ | *Recommend (✓)* | | *Approve (✓)* | |

**Summary of Key Issues**

**Performance Scorecard**

Key areas for operational standards in June 2021:

The Trust did meet the standard for:

- 52+ week wait trajectory
- All Cancers - 31 Days for 1st treatment and subsequent treatment (drugs)

The Trust did not meet the standards for:

- Zero 52 week waits
- Zero 104 week waits
- RTT performance percentage
- Diagnostic Waiting Times
- ED, DCH only and Combined with MIU
- All Cancers - 62 Day Referral to Treatment following an urgent GP referral
- Two week wait from referral to first seen
- Breast Symptomatic Two Week Wait from urgent GP referral to first seen
- All Cancers - 31 Day Subsequent Treatment (Surgery)

Looking forward to July 2021, it is anticipated that DCH will meet the standards for:

- Cancer 31 days (all)
- 52+ week wait trajectory

DCH will not meet the standard in July for:

- RTT
- The RTT waiting list size trajectory
- Diagnostic Waiting Times
- ED – 4 hour standard combined with MIU
- Cancer 62 day standard
- Cancer two week wait standard

| | |
|---|---|
| | • Cancer Breast symptomatic 2 week wait<br>• Zero 52 week waits<br>• Zero 104 week waits<br><br>**Escalation Reports**<br>The July Board sub-committees met as follows:<br>Monday 19 July: People and Culture Committee<br>Tuesday 20 July: Quality Committee, Finance and Performance Committee, Risk and Audit Committee.<br><br>The attached reports detail the significant risks and issues for escalation to Board for action, key issues discussed, decisions made, implications for the Corporate Risk Register and Board Assurance Framework (BAF), and items for referral to other committees, arising from each of the Board sub-committee meetings. |
| **Action recommended** | The Board of Directors is requested to:<br><br>1. **NOTE** the performance data<br>2. **NOTE** the escalations from the Board sub-committees. |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | N | |
| **Financial** | N | |
| **Impacts Strategic Objectives?** | Y | Operational performance and corporate governance underpins all aspects of the Trust's strategic objectives. |
| **Risk?** | Y | Implications for the Corporate Risk Register or the Board Assurance Framework (BAF) are outlined in the escalation reports. |
| **Decision to be made?** | N | Details of decisions made are outlined in the committee escalation reports. |
| **Impacts CQC Standards?** | Y | Operational performance and governance underpins all aspects of the CQC standards. |
| **Impacts Social Value ambitions?** | Y | Operational performance and corporate governance underpins all aspects of the Trust's social value ambitions. |
| **Equality Impact Assessment?** | N | N/A |
| **Quality Impact Assessment?** | N | N/A |

| Metric | Threshold/ Standard | Type of Standard | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | YTD | Movement on Previous Period | 12 Month Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safe** | | | | | | | | | | | | | | |
| Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days) | **0** | Contractual (National Quality Requirement) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | **1 (0.1)** | 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) | 3 (0.4) | 2 (0.3) | 1 (0.1) | 2 (0.3) | 4 (0.5) | **3 (0.4)** | **4 (0.5)** | **2 (0.2)** | **9 (0.4)** | ↑ | |
| Never Events | **0** | Contractual (National Requirement) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ↔ | |
| Serious Incidents investigated and confirmed avoidable | **N/A** | For monitoring purposes only | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | **N/A** | |
| Duty of Candour - Cases completed | **N/A** | For monitoring purposes only | 1 | 0 | 0 | 0 | 0 | 11 | 11 | 5 | 10 | 26 | **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 | 0 | **N/A** | |
| NRLS - Number of patient safety risk events reported resulting in severe harm or death | **10% reduction 2016/17 = 21.6** | Local Plan | 0 | 0 | **4** | **2** | **2** | 1 | **2** | 1 | **3** | **6** | ↓ | |
| Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days) | **10% reduction 2016/17 = 9.9** | Local Plan | 0 (0.0) | 0 (0.0) | **1 (0.1)** | **1 (0.1)** | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | ↔ | |
| Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days) | **N/A** | For monitoring purposes only | 0 (0.0) | 2 (0.3) | 0 (0.0) | 0 (0.0) | 1 (0.1) | 0 (0.0) | 0 (0.0) | 1 (0.1) | 0 (0.0) | 1 (0.0) | ↑ | |
| Emergency caesarean section rate | | | 16.4% | 27.5% | 20.5% | 19.5% | 20.9% | 22.3% | 20.1% | 26.2% | 21.6% | 22.6% | ↑ | |
| Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**) | **90%** | 2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement) | **88.9%** | 90.0% | 100% | 100% | 96.0% | 95.1% | 100% | 90.5% | N/A | 94.6% | ↓ | |
| Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017) | **90%** | 2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement) | 97.1% | 90.0% | 96.4% | **82.1%** | 95.7% | 95.7% | 96.0% | 96.6% | **88.9%** | 92.6% | ↓ | |
| Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**) | **90%** | 2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement) | **68.0%** | 91.3% | **75.0%** | **77.3%** | **57.9%** | **82.1%** | **83.3%** | **88.5%** | N/A | **86.4%** | ↑ | |
| Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017) | **90%** | 2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement) | 92.9% | 96.3% | 95.8% | **85.7%** | **84.2%** | 94.6% | **84.2%** | **88.9%** | **88.0%** | **87.5%** | ↓ | |
| **Effective** | | | | | | | | | | | | | | |
| SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD] | **2 ('as expected') or 3** | Contractual (Local Quality Requirement) | 2 | 2 | 2 | 2 | **1** | N/A | N/A | N/A | N/A | N/A | ↓ | **N/A** |
| SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD] | **≤1.14 (ratio between** | Contractual (Local Quality Requirement) | 1.10 | 1.10 | 1.12 | 1.13 | **1.14** | N/A | N/A | N/A | N/A | N/A | ↓ | |
| Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months | **100** | Contractual (Local Quality Requirement) | **109.1** | **107.2** | **106.4** | **106.1** | **106.4** | 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) | **103.8** | **102.4** | 99.8 | 97.0 | 99.2 | N/A | N/A | N/A | N/A | N/A | ↓ | |
| Stroke - Overall SSNAP score | **C or above** | Contractual (Local Quality Requirement) | B | | | B | | | 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 admission | **90%** | Contractual (Local Quality Requirement) | **49.8%** | **42.0%** | **57.7%** | **65.9%** | **70.5%** | **54.5%** | **59.8%** | **58.5%** | **56.4%** | **58.3%** | ↓ | |
| Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed | **90%** | Contractual (Local Quality Requirement) | 100.0% | **89.5%** | 100.0% | 100.0% | 100.0% | 97.5% | 100.0% | 100.0% | 100.0% | 100.0% | ↔ | |
| Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services | **90%** | Contractual (Local Quality Requirement) | **86.1%** | **73.3%** | **83.3%** | **75.0%** | **88.0%** | **60.6%** | **83.3%** | **85.7%** | **60.0%** | **80.9%** | ↓ | |
| **Caring** | | | | | | | | | | | | | | |
| Compliance with requirements regarding access to healthcare for people with a learning disability | **Compliant** | For monitoring purposes only | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | ↔ | |
| Complaints - Number of formal & complex complaints | **N/A** | For monitoring purposes only | 27 | 34 | 33 | 18 | 22 | 38 | 21 | 16 | 27 | 64 | ↓ | |
| Complaints - Percentage response timescale met | **Dec '18 = 95%** | Local Trajectory | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | ↔ | |
| Friends and Family - Inpatient - Recommend | **96%** | Mar-18 National Average | **94.2%** | **94.9%** | **89.1%** | 96.9% | **94.6%** | **94.9%** | **94.5%** | **93.9%** | **93.2%** | **93.9%** | ↓ | |
| Friends and Family - Emergency Department - Recommend | **84%** | Mar-18 National Average | 89.1% | 89.9% | 87.8% | 95.7% | 89.7% | 90.1% | 88.0% | 87.6% | 85.4% | 86.9% | ↓ | |
| Friends and Family - Outpatients - Recommend | **94%** | Mar-18 National Average | **93.1%** | 95.2% | **93.6%** | 94.8% | **93.3%** | 94.6% | **93.0%** | 94.2% | **93.6%** | **93.6%** | ↓ | |
| Number of Hospital Hero Thank You Award applications received | **2016/17 = 536 (44.6 per** | Local Plan (2016/17 outturn) | **5** | **9** | **6** | N/A | N/A | N/A | N/A | N/A | N/A | N/A | ↓ | |

| Metric | Threshold/ Standard | Type of Standard | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | YTD | Movement on Previous Period | 12 Month Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Responsive** | | | | | | | | | | | | | | |
| Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position) | **92%** | Contractual (National Operational Standard) | **49.4%** | **52.1%** | **53.3%** | **51.3%** | **50.5%** | **50.9%** | **51.5%** | **54.6%** | **56.4%** | **56.4%** | ↑ | |
| RTT Incomplete Pathway Waiting List size | **Trajectory June = 17812** | | 15,659 | 16,038 | 16,251 | 16,110 | 16,162 | 16,853 | 17,194 | **17666** | **17928** | **17928** | ↓ | |
| Cancer (ALL) - 14 day from urgent gp referral to first seen | **93%** | Contractual (National Operational Standard) | **57.2%** | **65.4%** | **73.1%** | **61.7%** | **76.0%** | **79.1%** | **69.1%** | **78.0%** | **55.6%** | **66.8%** | ↓ | |
| Cancer (Breast Symptoms) - 14 day from gp referral to first seen | **93%** | Contractual (National Operational Standard) | **14.3%** | **9.1%** | **0.0%** | **21.4%** | **27.5%** | **29.3%** | **0.0%** | **3.7%** | **8.3%** | **4.5%** | ↑ | |
| Cancer (ALL) - 31 day diagnosis to first treatment | **96%** | Contractual (National Operational Standard) | 98.7% | 98.2% | 97.9% | 97.9% | **93.1%** | 97.7% | 96.7% | 97.7% | **93.3%** | 96.1% | ↓ | |
| Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery | **94%** | Contractual (National Operational Standard) | 100.0% | 100.0% | 100.0% | **71.4%** | 100.0% | **77.8%** | 100.0% | **77.8%** | 100.0% | **93.8%** | ↑ | |
| Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen | **98%** | Contractual (National Operational Standard) | 100.0% | 100.0% | 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% | - | - | - | - | - | - | - | - | - | ↔ | |
| Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post) | **85%** | Contractual (National Operational Standard) | **73.0%** | **76.1%** | **71.4%** | **75.7%** | **67.7%** | **83.9%** | **81.0%** | **74.0%** | **74.6%** | **76.6%** | ↑ | |
| Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post) | **90%** | Contractual (National Operational Standard) | **57.1%** | **33.3%** | 100.0% | **76.9%** | 100.0% | **71.4%** | **62.5%** | **83.3%** | **54.8%** | **64.6%** | ↓ | |
| % patients waiting less than 6 weeks for a diagnostic test | **99%** | Contractual (National Operational Standard) | **66.1%** | **72.8%** | **73.6%** | **75.9%** | **82.5%** | **79.9%** | **80.0%** | **80.4%** | **82.4%** | **81.0%** | ↑ | |
| ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge | **95%** | Contractual (National Operational Standard) | **86.2%** | **90.6%** | **84.2%** | **78.8%** | **79.2%** | **81.0%** | **80.7%** | **74.5%** | **70.9%** | **75.3%** | ↓ | |
| ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016) | **95%** | Contractual (National Operational Standard) | **91.8%** | **94.1%** | **90.2%** | **87.3%** | **88.5%** | **90.3%** | **86.6%** | **82.5%** | **79.7%** | **82.8%** | ↓ | |
| **Well Led** | | | | | | | | | | | | | | |
| Annual leave rate (excluding Ward Manager) **% of weeks within threshold** | **11.5 - 17.5%** | | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Sickness rate (one month in arrears) | **3.3%** | Internal Standard reported to FPC | **3.55%** | **3.50%** | 3.29% | **4.89%** | **4.03%** | 3.13% | 3.08% | 3.33% | NA | 3.2% | ↓ | |
| Appraisal rate | **90%** | Internal Standard reported to FPC | **74%** | **76%** | **77%** | **76%** | **76%** | **76%** | **77%** | **79%** | **78%** | **78%** | ↓ | |
| Staff Turnover Rate | **8 -12%** | Internal Standard reported to FPC | 8.85% | 8.6% | 8.4% | 8.23% | 7.7% | 7.7% | 7.7% | 8.3% | 8.1% | 8.0% | ↑ | |
| Total Substantive Workforce Capacity | | Internal Standard reported to FPC | 2,599.7 | 2,663.5 | 2630.9 | 2,644.2 | 2,720.6 | 2,781.5 | 2,798.5 | 2771.36 | 2,801.8 | 2,790.6 | **N/A** | |
| Vacancy Rate (substantive) | **<5%** | Internal Standard reported to FPC | **7.2%** | **6.4%** | **6.4%** | **6.4%** | **5.7%** | **6.4%** | **6.6%** | **7.8%** | **7.7%** | **7.4%** | ↑ | |
| Total Substantive Workforce Pay Cost | | Internal Standard reported to FPC | **10,338.4** | **10,628.8** | **10,415.30** | **10,703.0** | **10,978.2** | **18,872.1** | **11,215.1** | **11,068.20** | **11,064.0** | **11,141.7** | ↑ | |
| Number of formal concerns raised under the Whistleblowing Policy in month | **N/A** | Internal Standard reported to FPC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ↔ | |
| Essential Skill Rate | **90%** | Internal Standard reported to FPC | **87%** | **87%** | **88%** | **87%** | **87%** | **88%** | **87%** | **88%** | **88%** | **88%** | ↔ | |
| Elective levels of contracted activity (activity) | **2019/20 = 30,584** | | **2,135** | **2,212** | **2,149** | **1,904** | **1,865** | **2,434** | **2,017** | **2,197** | **2,308** | **6,522** | ↑ | |
| Elective levels of contracted activity (£) Including MFF | **2019/20 = £30,721,866** | | **£1,985,199** | **£2,108,025** | **£2,004,285** | **£1,524,140** | **£1,468,667** | **£2,207,635** | **£2,030,087** | **£2,284,593** | **£2,398,396** | **£6,713,076** | ↑ | |
| Surplus/(deficit) (year to date) | **2021/22 = Breakeven** | Local Plan | (999) | (891) | (1,901) | (2,055) | (805) | 387 | **(502)** | **(693)** | **(717)** | **(717)** | **N/A** | **N/A** |
| Cash Balance | **2021/22 - M3 = 14,234** | | 24,590 | 24,589 | 24,134 | 25,648 | 29,286 | 17,698 | 17,900 | 16,319 | 15,841 | N/A | ↓ | |
| CIP - year to date (aggressive cost reduction plans) | **No target for the first qtr of** | Local Plan | Yet to be decided | Yet to be decided | Yet to be decided | Yet to be decided | Yet to be decided | Yet to be decided | N/A | N/A | N/A | N/A | **N/A** | **N/A** |
| Agency spend YTD | **2021/22 = No Annual value** | | **5,458** | 6,358 | 7,199 | 8,117 | 8,985 | **1,398** | **1,031** | **1,299** | **3,206** | **3,206** | **N/A** | **N/A** |
| Agency % of pay expenditure | | | **6.4%** | **6.6%** | **6.6%** | **6.7%** | **6.7%** | **6.7%** | **7.9%** | **8.4%** | **8.6%** | **8.3%** | ↓ | |

**Movement Key**

**Favourable Movement** ↑
**Adverse Movement** ↓
**No Movement** ↔

**Achieving Standard**
**Not Achieving Standard**

## Key Performance Metrics Summary

| | Metric | Standard | May-21 | Jun-21 |
|---|---|---|---|---|
| Quality | MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days) | **0** | 0 (0.0) | 0 (0.0) |
| | E-Coli hospital acquired cases (Rate per 1000 bed days) | **50% reduction by 2023** | 0 (0.0) | 2 (0.2) |
| | Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days) | **16** | **4 (0.5)** | **2 (0.2)** |
| | Never Events | **0** | 0 | 0 |
| | Serious Incidents declared on STEIS (confirmed) | **51 (4 per month)** | 0 | 1 |
| | SHMI - Rolling 12 months, 4 months in arrears (Oct-19 to Sep-20) | **<1.14** | **1.14** | |
| | Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Nov-19 to Oct-20) | **100** | **106.4** | |
| Performance | RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position) | **92%** | **54.6%** | **56.4%** |
| | RTT Incomplete Pathway Waiting List size | **Trajectory June = 17812** | **17,666** | **17,928** |
| | All cancers maximum 62 day wait for first treatment from urgent GP referral | **85%** | **74.0%** | **74.6%** |
| | Maximum 6 week wait for diagnostic tests | **99%** | **80.4%** | **82.4%** |
| | ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016) | **95%** | **82.5%** | **79.7%** |
| Finance | Elective levels of contracted activity (£) | **2019/20 = £30,721,866 £2,560,155/month** | **2,284,593** | **2,398,396** |
| | Surplus/(deficit) (year to date) | **2021/22 = Breakeven YTD M3 = £(439)** | **(693)** | **(717)** |
| | CIP - year to date (aggressive cost reduction plans) | **No target for the first qtr of the year** | N/A | N/A |
| | Agency spend YTD | **2021/22 = No Annual value YTD M3 = £1,638** | **1,299** | **3,206** |

Rating Key

# Escalation Report

**Executive / Committee: People and Culture Committee (formerly Workforce Committee)**

**Date of Meeting: 19th July 2021**

**Presented by: Margaret Blankson**

| | |
|---|---|
| **Significant risks / issues for escalation to Board for action** | • The committee was concerned about staff resilience given the continued workload pressures and changing national COVID guidance.<br>• Whilst there were no 'Red Flag' Safer staffing incidents, the committee noted an increasing number of 'amber' rated incidents. |
| **Key issues / other matters discussed by the Committee** | The committee received, discussed and noted the following reports:<br>• People Performance Report and new Dashboard<br>• Pan-Divisional Workforce Planning Report updated on gaps, mitigations and residual risk. New staffing models the international nurse recruitment drive were noted.<br>• Quarterly Risk Report<br>• Bank and Agency Use and Expenditure Report and work in progress to ensure consistent, cost efficient practice across the Trust<br>• Divisional Bi-monthly Update – Family Services and Surgical Division was deferred<br>• Dignity and Respect at Work Programme for staff banded 2 – 6 would commence in September and supplement the Inclusive Leadership Programme<br>• There were no 'Red Flag' safe staffing incidents. |
| **Decisions made by the Committee** | The Committee approved:<br>• Medical Revalidation Responsible Officers Reports, recommending that the Statement of compliance be approved by the Board. |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | • The committee noted how information from various sources (incidents, Freedom to Speak Up feedback, Patient Advice and Liaison Service etc) were triangulated |
| **Items / issues for referral to other Committees** | • Medical Revalidation Responsible Officers Report and Statement of Compliance are recommended to the Board for approval and signature. |

**Escalation Report**

**Committee: Quality Committee**

**Date of Meeting: 20th July 2021**

**Presented by: Judy Gillow/Nicky Lucey**

| | |
|---|---|
| **Significant risks / issues for escalation to Committee / Board for action** | • Staffing – risks and mitigations. Managing the risk within the Risk Appetite of the Trust<br>• Stroke Unit – deep dive planned |
| **Key issues / matters discussed at the Committee** | The committee received, discussed and noted the following reports:<br>• Quality and Safety Performance Report – good level of compliance overall with quality metrics<br>  ○ Increasing Clostridium Difficile cases locally and nationally<br>  ○ Increasing mixed sex accommodation breaches<br>• Maternity Safety Update – introduction of the new digital record system and ongoing development of the Dashboard<br>• Pan-Divisional Report of Workforce risks and mitigations outlined the strategy for increased international recruitment, consideration and implementation of new staffing models and roles and increased use of the Apprenticeship scheme to attract and train staff<br>• Divisional Exception Report from<br>  ○ Urgent and Integrated Care Division included an update on Stroke Unit challenges<br>  ○ Family and Surgical Services Division included an update on the cultural development work being undertaken in Theatres<br>• Sub-Committee Minutes and Escalations from Infection Prevention and Control \|Group |
| **Decisions made by the Committee** | • None |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | • Staffing risks as outline above |
| **Items / issues for referral to other Committees** | • Theatre Cultural Review<br>• Revised workforce model for the Older Peoples' Unit |

# Escalation Report

**Committee: Finance and Performance Committee**

**Date of Meeting: 20th July 2021**

**Presented by: Stephen Tilton**

| | |
|---|---|
| **Significant risks / issues for escalation to Board for action** | • Recommend the Premises Assurance Model Self-Assessment to the Board for approval<br>• The committee endorsed a commitment of £315k for the Estates Masterplan refresh and recommend to the Board for approval |
| **Key issues / other matters discussed by the Committee** | The Committee received, discussed and noted the following reports and updates:<br>• MS Office 365 review<br>• Performance Report noting the EPMG Report and new Dashboard<br>  ○ Improved 52 week wait position<br>  ○ Increased number of cancer referrals in dermatology and breast services<br>  ○ Work to address typing backlog<br>• Technological solutions supporting ERP<br>• NHS System Oversight Framework and system performance metrics<br>• Finance Report including Benchmarking<br>  ○ The Trust was £300k variant from finance plan this month<br>  ○ Changes to the Elective Recovery Fund activity thresholds<br>• Divisional Exception Reporting<br>  ○ Urgent and Integrated Care including an update on Stroke Unit agency spend<br>  ○ Family Services and Surgical Services<br>• Pan-Divisional Report on Workforce Risks – the committee supported an 'invest to save' approach, the development of new supporting roles and further international recruitment. Implementation of greater rigor around temporary staffing solutions<br>• Strategic Estates Masterplan quarterly update<br>• No Sub-Group Escalation Reports were received. |
| **Decisions made by the Committee** | The following items were approved by the committee:<br>• Premises Assurance Model Self-Assessment – recommended to the Board for approval<br>• Proposal to review prior investments approved by the committee<br>• Endorsed £315k for the Estates Masterplan refresh<br>• The revised Procurement Strategy was approved |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | • Risk Assessment of Unfunded Capital Schemes<br>• Pan-Divisional Report on Workforce Risks |
| **Items / issues for referral to other** | • |

| Committees | |
|---|---|

# Escalation Report

**Committee: Risk and Audit Committee**

**Date of Meeting: 20th July 2021**

**Presented by: Ian Metcalfe**

| | |
|---|---|
| **Significant risks / issues for escalation to Board for action** | • Moderate assurance was received from Internal Audit Reports:<br>  ○ Theatre Utilisation<br>  ○ Data Quality Processes |
| **Key issues / other matters discussed by the Committee** | The committee received and noted the following reports:<br>• Internal Audit Progress Report and follow up recommendations<br>• Counter Fraud update and amber ratings in the Government functional standards submission<br>• Corporate Risk Register – emphasising the workforce risks and that these were being tolerated within the Trust's Risk Appetite<br>• Board Assurance Framework – noting further work to incorporate and align with the new strategy and to ensure the inclusion of sustainability risks<br>• Risk Review of unfunded Capital schemes – further investment of £0.5m<br>• Register of Interests Update<br>• Quality Account 2020/21 |
| **Decisions made by the Committee** | The committee approved the following:<br>• Internal Audit Progress Reports |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | • Risk review of unfunded Capital schemes noting £0.5m investment in some schemes<br>• Workforce risks and mitigations |
| **Items / issues for referral to other Committees** | • None |

| | |
|---|---|
| **Meeting Title:** | Board of Directors |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | **Recovery Framework** |
| **Responsible Director:** | Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships |
| **Author:** | Natalie Violet, Corporate Business Manager to the Chief Executive |

| | |
|---|---|
| **Confidentiality:** | Not confidential |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Senior Management Team Meeting | 23 June 2021 | Supported |
| Executive Management Team Meeting | 17 June 2021 | Updates to the roadmap and governance structure recommended, supported |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | The purpose of the report is to provide the Trust Board with an overview and seek approval of the proposed Recovery Framework following the COVID-19 pandemic. | | | | | | | |
| | *Note (✓)* | | *Discuss (✓)* | | *Recommend (✓)* | | *Approve (✓)* | ✓ |
| **Summary of Key Issues** | Recovery work has been ongoing within the organisation since the end of wave two. This framework sets out a guide to DCH's approach to the recovery which may evolve and be informed by any System and National guidance as they are issued.<br><br>The organisations recovery priority is twofold – our NHS people and clinical services. The approach is in line with the national 2021/22 Priorities and Operational Planning Guidance, published on 25 March 2021. With objectives for both people and service recovery aligned to this guidance.<br><br>Elective recovery trajectories will be provided with sub-board committee reporting to include recovery metrics and performance against trajectory from July onwards. Narrative reporting to the Board will take place on a regular basis from September. | | | | | | | |
| **Action recommended** | The Trust Board is recommended to:<br>1. **APPROVE** the Trust's Recovery Framework. | | | | | | | |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | Y | Failure to produce a robust recovery framework could result in further deterioration of standards and impact the achievement of ERF. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus. |
| **Financial** | Y | Failure to produce a robust recovery framework could result in further deterioration of standards and impact the achievement of ERF. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus. |

| | | |
|---|---|---|
| **Impacts Strategic Objectives?** | Y | Delivery of outstanding care. Significant impact on patient and staff experience and reputation of poor performance with commissioners, regulators, and the public. |
| **Risk?** | Y | The clinical impact of COVID-19 on planned care and patients that are not clinically urgent is not understood yet, but a clinical risk stratification programme is in development, which follows the nationally published guidelines. Harm cannot be determined until the patient is seen. |
| **Decision to be made?** | Y | To seek approval of the proposed approach to recovery following the COVID-19 pandemic. Following approval by the Board trajectories will be provided at the next Trust Board meeting. Monitoring will take place through the integrated performance report and the reporting presented to the sub-committees. |
| **Impacts CQC Standards?** | Y | Ensuring a robust recovery framework is produce links with the CQC well-led domain. |
| **Impacts Social Value ambitions?** | N | The recovery approach supports the organisations Social Value ambitions by being a supportive employer and recovering elective services for our local communities, embedding equity in health outcomes into restart processes. |
| **Equality Impact Assessment?** | N | The Elective Performance Management Group (EPMG) are focusing on addressing waiting list health inequalities, with a particular focus on ethnicity and deprivation. |
| **Quality Impact Assessment?** | N | Quality Committee are providing oversight of patient outcomes. |

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

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# Recovery Framework

**Nick Johnson**
Deputy Chief Executive and
Director of Strategy, Transformation & Partnerships
June 2021

*Outstanding care for people in ways which matter to them*

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# Context

- As the immediate COVID-19 pressure subsides and vaccination numbers increase, planning the recovery of staff and services is imperative.
- Recognising full recovery will be a long-term process.
- The following slides set out a framework to guide DCH's approach to the recovery.
- This approach may evolve and be informed by any System and National guidance as they are issued.

# 2021/22 Priorities and Operational Planning Guidance

Published on 25 March 2021. The national priorities are:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.

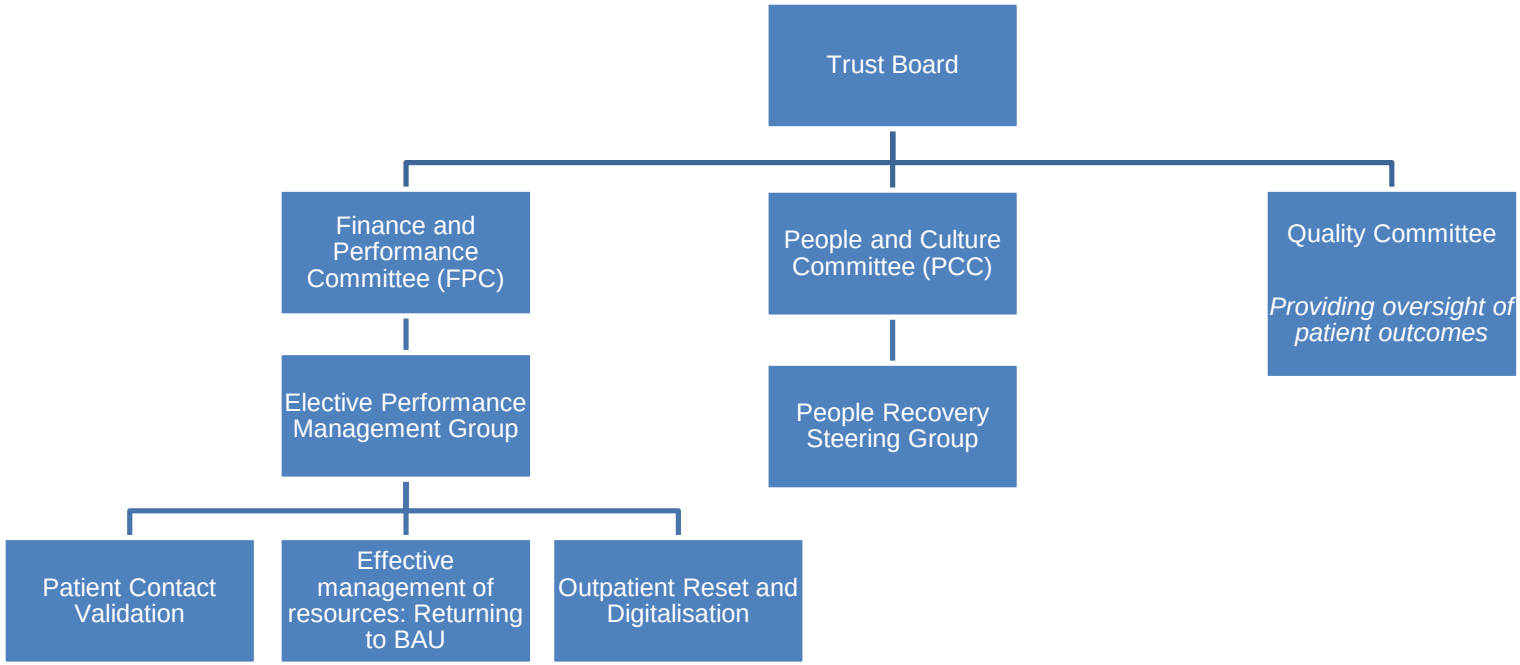
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.

F. Working collaboratively across systems to deliver these priorities.

# Governance

The recovery priority is twofold, our NHS people and clinical services whilst looking forward and learning from the innovations implemented during the pandemic.



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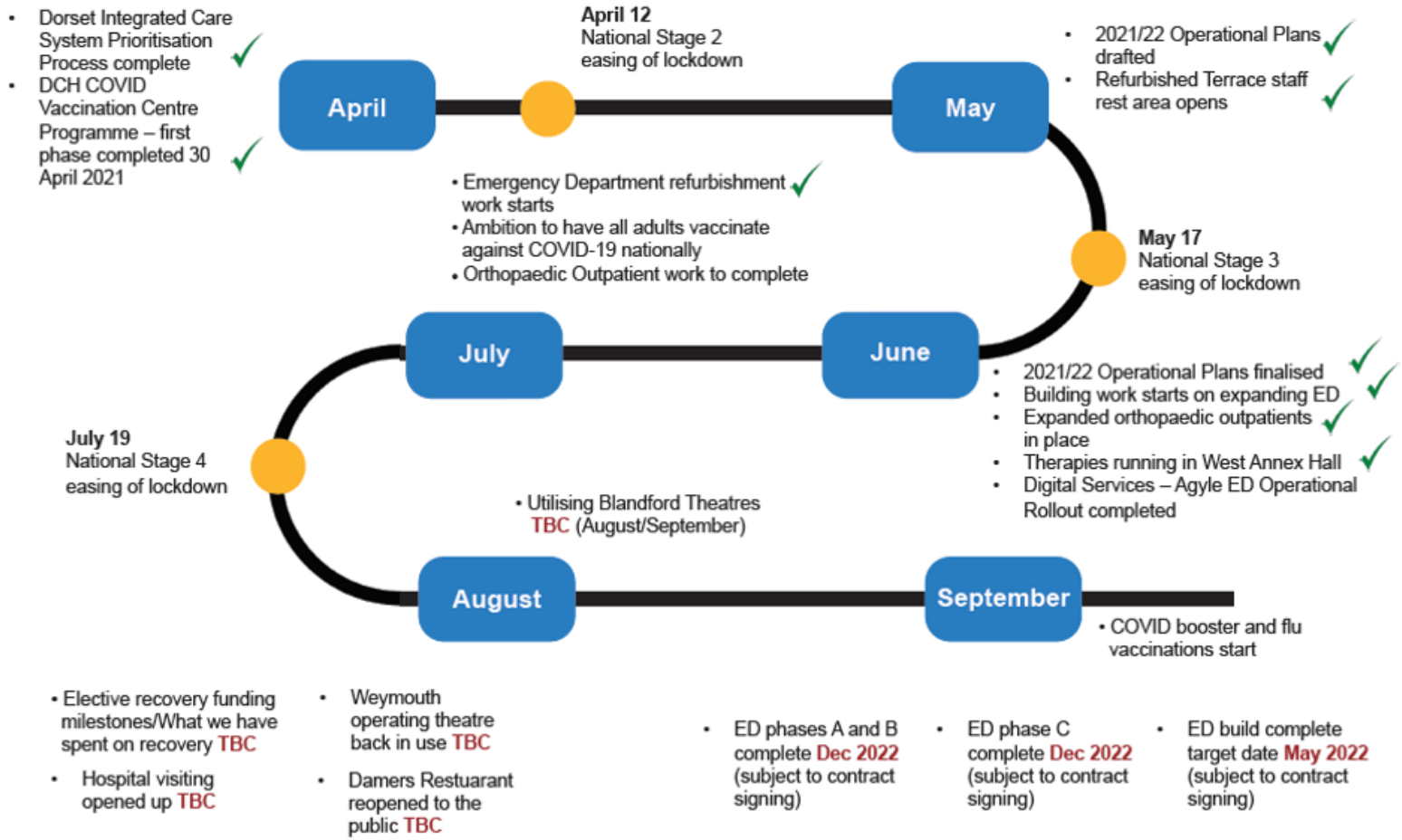
# DCH Recovery Roadmap



# People Recovery

- During wave one and two of the pandemic DCH was fortunate to be minimally impacted by patients with COVID-19.
- Staff in elderly care wards and areas repurposed to support pandemic activity were more highly affected.
- Many more staff struggled with the requirement to step down of activity, knowing this could impact on patient outcomes longer term due to delays in access to treatment. These people are keen to return to delivering services for patients.
- Staff in support services were impacted by huge volumes of work responding to the reconfiguration of care delivery and remote working.
- Analysis of people metrics (sickness, turnover, OH referrals) over the last 3 years shows minimal variation for the pandemic period. Sickness and turnover show improvements for the pandemic period.

However, the longer term impact for people living through a pandemic is unknown. Many people will have lost family and friends and the impact of social isolation, fear and anxiety and the stark emergence of health inequalities particularly impacting minority ethnic communities cannot be underestimated.

# People Recovery - Objectives

| What | How |
|---|---|
| To continue to embed the health and wellbeing offers which will provide ongoing well-being support to staff | • Refine and clarify 'the offer'<br>• Ongoing communication campaign<br>• Engagement with staff networks, staff side colleagues, staff champions to promote<br>• Health & wellbeing steering group TOR and membership to be refreshed to become a People recovery steering group (EH Chair) |
| Embed wellbeing check ins as part of regular 121's, team meetings and appraisal | • Communicate people recovery context and approach at SMT and Clinical leads forum<br>• HR and OD team support to managers<br>• Track with 'appraisal quality' data |
| Proceed at pace with the 'transforming people practices' programme to support inclusion and wellbeing at work | • Programme of work in place<br>• Inclusive leadership programme roll out |
| Monitor a defined subset of people recovery metrics at People recovery steering group, divisional performance meeting and PCC | • Quarterly pulse check division/corporate area data (engagement measures)<br>• Appraisal quality data<br>• Sickness (long term & short term) & Turnover<br>• People performance report to include narrative triangulating performance with staff recovery for assurance |

# People Recovery – Next Steps

- People recovery aligns with DCH strategy people elements:
  - We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes
  - We will create an environment where everyone feels they belong, they matter and their voice is heard
  - We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves
- The Health and Wellbeing steering group TOR and membership is refreshed and becomes the People Recovery (H&WB) steering group – chair Emma Hallett, membership includes divisional/department reps, OH, Counselling service rep, H&WB lead
- Measures to track recovery will be used in divisional monthly performance reviews
- Narrative in the People performance report to include narrative triangulating performance with staff recovery for assurance

# Service Recovery

- The principle aim is to ensure that recovery is delivered in a sustainable way.
- This will require an understanding of what element of the current backlog relates solely to COVID and what element relates to recurrent increases in demand.

Key objectives of service recovery include:

- To do as much as we can with what we have and by working with system partners.
- To minimise harm and prioritise care based on clinical need.
- To embed equity in health outcomes into restart processes.

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# Service Recovery Governance

**DCH:** Finance and Performance Committee (Sub-Board committee)
**System:** ECOG, SLT, OFRG

**Governance reporting direction**

**Elective Performance Management Group (EPMG), meets fortnightly**

- Elective recovery oversight
- Performance monitoring and management
- Activity management and recovery (ERF)
- Waiting list oversight and performance management
- DM01, Cancer and RTT performance KPIs
- Address waiting list health inequalities, with a particular focus on ethnicity and deprivation

**EPMG**

**Exec sponsor:** Chief Operating Officer

**Chair:** Associate Director of Performance

**Work streams**

**1) Patient Contact Validation**

- Clinically led validation of all W/L
- Contacting all patients to confirm place on W/L
- Shared decision making with patient and clinician about next steps
- Effective & regular communication with patients
- Robust technical validation processes- refresh

**2) Effective management of resources: Returning to BAU**

- PTL management
- Theatre efficiency and 6-4-2
- Move to a 3 theatre list day
- Clinic utilisation, incl. PAU
- Patient Access training
- Clinic room utilisation
- Workforce resource analysis
- Outsourcing & Insourcing

**3) Outpatient Reset and Digitalisation**

- Online referral management
- Increasing A&G via e-RS
- PIFU
- Virtual offer and reporting activity
- Digital clinic outcome forms
- Speech recognition
- Centralisation of follow up booking
- Move to a 3 clinic session day

*Outstanding care for people in ways which matter to them*

# Service Recovery Ambition 2021/22

**Diagnostics**

- Deliver 90% DM01 performance by end of Q2 with 99% by end of Q4

**RTT**

- Wait list size to be no greater than that at January 2020
- % wait list > 52 ww to reduce each quarter, first milestone will be < 5% by end of Q1
- Reduce the number of non-admitted patient pathways > 52ww, aim to have zero by end of Q4
- No > 104 ww by end of Q3

**Outpatient backlog/follow ups**

- To validate and clinically prioritise the OP FU wait list and reduce the number of patient waiting past their due date compared to March 2021 by 10% compared to March 2021 by Q4

**Planned waiting list**

- To validate and clinically prioritise the Planned wait list and reduce the number of patient waiting past their due date by 5% compared to March 2021, ensuring all national waiting times standards are applied as appropriate.

**Cancer**

- To acheive 62 day standard by Q2
- To maintain a PTL size of below 1,000
- To acheive all 31 standards by Q2
- To acheive 2ww by Q3
- To acheive FDS of 75% by Q3

- Detailed trajectories and a dashboard are being developed and will be reported through to Finance and Performance Committee.

# 2021/22 priorities and operational planning guidance

The 2021/22 priorities and operational planning guidance, sets out a number of key actions. Where these actions are for providers to individually complete, they are included within this recovery plan.

| 2021/22 priorities and operational planning guidance- Section C1, C2 and ERF gateways (where operational) | Work streams |
|---|---|
| Prioritise the clinically most urgent patients, e.g. for cancer and P1/P2 surgical treatments | 2 |
| Incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk (drawing on both primary and secondary care) | 1 |
| Include actions to maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable. Shared decision making and treatment reviews between patients and clinicians, keeping waiting patients informed of next steps in their treatment, including discussion of alternative treatment options | 1 |
| Maintaining waiting list data quality, detailed validation of the weekly Waiting List Minimum Dataset (MDS) uploads, to ensure waiting list data are complete and accurate | 1 |
| Address the longest waiters and ensure health Inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation | EPMG |
| Return to pre-COVID activity levels and beyond. Thresholds, as a percentage of the value of the 2019/20 activity:<br>• 70% for April 2021<br>• 75% for May 2021<br>• 80% for June 2021<br>• then 85% from July to September 2021 | 2 |
| Recovery of diagnostic activity volumes to the highest possible levels; particularly to support elective recovery | 2 |

# 2021/22 priorities and operational planning guidance

The 2021/22 priorities and operational planning guidance, sets out a number of key actions. Where these actions are for providers to individually complete, they are included within this recovery plan.

| 2021/22 priorities and operational planning guidance- Section C1, C2 and ERF gateways (where operational) | Work streams |
|---|---|
| Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower) | 2 |
| Meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%. | 2 |
| Avoid outpatient attendances of low clinical value. Increased mobilisation of Advice & Guidance and Patient Initiated Follow Up services. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don't involve a procedure | 3 |
| Introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider; including personalised stratified follow up for cancer patients, avoiding unnecessary follow up attendances, and providing faster access to follow up appointments where clinically necessary | 3 |
| Collaborating across primary and secondary care to treat more patients without the need for an onward referral, including increasing the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances | 3 |
| Create clear accountability for elective recovery | EPMG |
| Evidence of common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data | 2 |

# Next Steps

- Framework approval:
  - EMT 17/06/21
  - SMT 23/06/21
  - Trust Board 28/07/21

- Elective recovery trajectories for approval:
  - FPC 20/07/21
  - Trust Board 28/07/21

- Sub-board committee reporting to include recovery metrics and performance against trajectory from July onwards.

- Narrative reporting to Trust Board on a regular basis from September.

| | |
|---|---|
| **Meeting Title:** | Board of Directors Part One |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | **Responsible Officer Annual Board Report** |
| **Responsible Director:** | Professor Alastair Hutchison |
| **Author:** | Dr Julie Doherty / Carol Mogford |

| | |
|---|---|
| **Confidentiality:** | *No* |
| **Publishable under FOI?** | *Yes* |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| People and Culture Committee | 19 07 21 | Recommended. |
| | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | The Board is recommended to approve the report. Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. | | | | | | | |
| | *Note (✓)* | | *Discuss (✓)* | | *Recommend (✓)* | | *Approve (✓)* | *x* |
| **Summary of Key Issues** | The Trust continues to meet all statutory duties in relation to medical revalidation & RO regulations.<br><br>Our main risk for the 2022-23 appraisal year relates to reaching & maintaining target appraisal rates as we are predicted to have a shortage of appraisers to meet the requirements of our increased numbers of locally employed doctors (LED).<br><br>Divisions still need to be mindful of the need to put forward suitable candidates to take on the role of medical appraisal. We are also reviewing appraisal processes for locally employed doctors (LED) with the aim of making appraisal less onerous and more supportive. By the proposal to mirror the Annual Review of Competency Progression (ARCP) process in place at the Deanery for trainees with a National Training Number (NTN) we also hope to reduce the burden on our systems for finding sufficient numbers of appropriately trained and confident appraisers for LED. The proposal for an ARCP Panel will however be dependent upon the LED being allocated a trained educational or clinical supervisor (which will have a cost implication to the Trust).<br><br>The introduction of a Revalidation & Appraisal Governance Group we hope will support Board level accountability for quality of medical appraisal.<br><br>The GMC Regional Liaison Service offers training to support Revalidation and may be something the Board would wish to consider for one of their development days. (GMC Handbook Principle 1a) | | | | | | | |
| **Action recommended** | The Board is recommended to:<br><br>1. **APPROVE** the report. Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I | | | | | | | |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | Y | Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I |
| **Financial** | N | |
| **Impacts Strategic Objectives?** | N | |
| **Risk?** | Y | The main risk for the 2022-23 appraisal year relates to reaching & maintaining target appraisal rates as we are predicted to have a shortage of appraisers to meet the requirements of our increased numbers of locally employed doctors (LED). |
| **Decision to be made?** | N | |
| **Impacts CQC Standards?** | N | |
| **Impacts Social Value ambitions?** | N | |
| **Equality Impact Assessment?** | N | |
| **Quality Impact Assessment?** | N | |

# Responsible Officer (RO) Annual Board Report

**For the period 1 April 2020 – 31 March 2021**

Date of Report: 30/06/21

Authors: Dr Julie Doherty (RO)

Carol Mogford (HR)

## Executive summary

The Annual Board Report sets out the key requirements for compliance with RO regulations and provides a format to demonstrate not only basic compliance but continued improvement over time.

*Impact of the Pandemic on appraisal & revalidation:*
On 19 March 2020 Professor Stephen Powis, National Medical Director & RO for NHS England and Improvement (NHSE/I) wrote to all RO's to inform them that due to changes to professional standards activities in light of Government advice on managing the Covid-19 outbreak appraisals should be cancelled until further notice. Affected appraisals were to be classified as 'approved missed appraisals'. In addition, the Annual Organisational Audit for 2019/20 was cancelled. This impacted our recorded appraisal rates.
The GMC also issued guidance that doctors who were due to revalidate before the end of September 2020 would have their revalidation date deferred for one year.

Professor Powis issued a further letter on 3 September 2020 to advise of a more supportive & flexible approach to appraisal with less emphasis on paperwork. A new 2020 appraisal template was agreed for use by medical practitioners should they wish to use this in place of our PReP IT portfolio or a MAG4 template. He recommended a restart to appraisal in October 2020 with the expectation of a return to normal levels of activity by April 2021. NHSE/ I subsequently advised that missed appraisals from 1 April 2021 would return to being classed as either approved (e.g relating to parental, compassionate or sick leave or sabbatical) or unapproved (no valid reason or postponement form provided & agreed by the appraisal lead or RO).

He further advised in his letter of 30 April 2021:
Last year we cancelled the 2019/20 Annual Organisational Audit and we are now standing down the 2020/21 exercise. However, organisations will still be able to report on their appraisal data and impact of the Appraisal 2020 model later in the year. The annual Board report and Statement of Compliance is being updated to support this. The date for submission of this report is 24 September 2021.

*DCHFT Appraisal rates and revalidation recommendations*:

Overall appraisal rate for medical practitioners at DCHFT this year was 69.5%.

Our target appraisal rate in normal circumstances would be >92%.

Substantive consultant appraisal rate was 77%; for SASG 66% and for temporary / short term contract holders across all grades 56%. The latter group subdivides into locum consultant (75% appraisal rate); locum SASG (73% appraisal rate) and locum Trust grade doctors (45% appraisal rate). For 2020-21 temporary & short term contract holders accounted for 26.4% of doctors with a prescribed connection to DCHFT, compared to 12.1% last year.

Our audit of missed or incomplete appraisals identified that the vast majority were covid related.

45 doctors revalidated during the reporting year. All revalidation recommendations were submitted on time.

Our main challenges relating to appraisal & revalidation continue to be:

- The retention and recruitment of sufficient appraisers;
- Supporting locums and 'As & When' contract holders with gathering sufficient & appropriate supporting information for revalidation
- Peer support / CPD for case investigation & management when responding to concerns about a doctor's practice.

# DCHFT Annual Board Report

## Section 1 – General:

The board of Dorset County Hospital NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been cancelled.
2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Julie Doherty is the RO for DCHFT

Comments: DCHFT has a split Medical Director / RO role. This is managed by good communication and regular 1:1 meetings between the Medical Director (MD) and RO.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Comments: We remain short of medical appraisers. We continue to request that Divisions look within their Care Groups to identify appropriate and interested consultants and especially SASG doctors to take on the role of medical appraiser. Departments would need to find 0.2PA per appraiser within the job plan from their budgets.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

Comments: The Medical Appraisal Policy has been reviewed to strengthen arrangements regarding short term locum and As & When contract holders. The policy was ratified at LNC in May 2020

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Yes, we had an external visit from the HLRO NHSE& NHSI South West on 9 July 2019. Formal written feedback is not provided from the review, verbal feedback was provided at the time of the review

Action for next year: See Action Plan at appendix E

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Comments: We do consistently support these doctors in their CPD and progress towards their revalidation. Information regarding risk events / complaints is provided to the doctor to support reflection, professional development, revalidation and governance.

The updated Medical Appraisal & Revalidation Policy has the following guidance: Locum and short term fixed contract holders employed at DCHFT for >3months will be offered an appraisal if their appraisal anniversary falls within their time of employ at DCHFT. As & When contract holders will be offered a prescribed connection & an appraisal if they work 15-20 shifts per annum at DCHFT and DCHFT is their main employer.

MPIT forms used to transfer information when doctors have a prescribed connection to DCHFT.

Action for next year (including carry over from last year's action plan):

To strengthen governance and QA processes for locum's / Short – term contract (>3months) holders via

1. Introduce requirement for contract holder to meet with clinical lead and engage in local educational & clinical governance programme – via a 'contract of expectations. This will support the doctor in gaining evidence for appraisal and revalidation whilst also supporting systems for patient care & safety. (GMC handbook Principle 1b)
2. Introduce locum exit forms to provide doctors without a prescribed connection to DCHFT with feedback on their performance. NHSE & NHSI contacted for templates to share

## Section 2 – Effective Appraisal

**1.** All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including

Action from last year:

1. Review appraisal rates for locum, short term fixed contract holders and As & When contract holders to see if measures taken have improved rates.

Comments:
Appraisal takes account of all relevant information relating to the doctors scope of practice and fitness to practice. Scope of practice forms are in place to support appropriate information sharing across organisations where a doctor works. MPIT forms are used for RO to RO transfers of information.

Medical Appraisal & Revalidation Policy updated and ratified (May 2020) to include requirements for locum, short term fixed contract holders and As & When contract holders to be accepted for a prescribed connection and offered an appraisal – with the aim of improving appraisal rates for these doctors.

Appraisal rates impacted by covid pandemic so we shall carry over the action and review appraisal rates once we have returned to more normal activity levels

4

**2.** Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Actions from last year:

Liaison with Clinical Directors to discuss & review how Care Groups and departments monitor medical appraisal rates. Consider introduction of published RAG table to identify doctors nearing their appraisal anniversary and aid scheduling of their appraisal

Comments:

We request postponement forms from doctors where it is known that an annual appraisal is likely to be delayed e.g due to leave. The Revalidation team conduct an audit of missed appraisals. For 2020/21 the majority of missed or incomplete appraisals were related to covid-19. A small number were due to planned leave (various) and a smaller number due to work pressures for appraisees or appraisers. For new starters we aim that they keep their appraisal anniversary. Where the appraisal anniversary is not available the current process is that the doctor will be offered an appraisal 6-12 months from their start date.

Action for next year:

1. Carry over 2019/20 action. No progress made due to many appraisals being cancelled / postponed during the Pandemic.

**3.** There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year:

1. Policy revision to include further information regarding locum and short term contract holders

Comments:

The Medical and Dental Staff Appraisal and Revalidation Policy EM06 was ratified at the LNC on 5 May 2020 and republished via the Trust intranet. No changes were made during the annual review.

**4.** The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Actions from last year:

1. Aim for appraiser : appraisee ratio nearer 1:6

Comments:

We continue to see a number of our trained appraisers relinquish the role due to other pressures within their job plan. We manage to recruit new appraisers to fill the gap left when an appraiser leaves to take up a post elsewhere. Currently there are 3 doctors who are undertaking new appraiser training – this will help meet our shortfall of 22 doctors who do not yet have an identified & allocated appraiser.

We have seen a significant rise in the number of locally employed doctors (including Trust grade doctors and FY3 doctors) with a prescribed connection. These doctors require an annual appraisal and we struggle to identify appropriately trained appraisers relevant for their grade and professional development. Previously we asked their allocated clinical / educational supervisors to carry out appraisal. However we have subsequently identified that this is outside recommendations for trainee equivalent grades who would have an ARCP with a report from their supervisor contributing to their supporting information. Trust grades without an allocated supervisor find the appraisal process currently in place too onerous as this mirrors that for SASG / Consultants. Some of the SASG / Consultant appraisers who are not, in addition, trained educational / clinical supervisors are also uncomfortable appraising trainee equivalent grade doctors. Following a meeting between the RO, DME, LED (locally employed doctors) lead, appraisal lead and the Divisional Directors (DD) we are hoping to be able to reproduce an ARCP equivalent process locally for the LEDs. We hope this process will be less onerous, more relevant and supportive for the appraisee

Action for next year:

1. Explore the introduction of ARCP equivalent process for locally employed doctors. DME to liaise with UHS. DD, DME and LED lead to produce a business case to support educational supervision, SPA time and ARCP equivalent for LEDs)

**5.** Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Comments:

Medical appraisers are invited to attend the quarterly appraisers meetings for peer support. At these meetings we discuss updates from the Responsible Officer and Appraiser Network (ROAN) and from GMC ELA meetings. We discuss issues relating to appraisal and revalidation and explore how to continuously improve our systems. These meetings were held less frequently during the pandemic; having restarted they have been held virtually.

We have previously scheduled meetings on different days of the week to try to improve attendance rates though this did not boost rates significantly. The information is therefore also sent out in a quarterly newsletter from the RO and is available on the Medical Appraisal and Revalidation webpage (managed by the revalidation administration officer).

Performance as an appraiser is discussed at appraisal as part of their scope of practice. QA of outputs from appraisal via ASPAT on PReP. Feedback from ASPAT is available to the appraiser within their PReP portfolio (following liaison with PReP IT support team). The RO aims to complete~2 ASPAT per appraiser per annum, however this has been on hold during the pandemic. An annual feedback meeting with the RO is offered to appraisers (with variable take up). Appraisees also provide feedback to appraisers via PReP.

Initial external training (Miad) is provided for appraisers with 3 yearly refresher. The appraisal lead and RO are available to meet (and do so) with appraisers to discuss performance and / or training issues and support appraisers in QI.The appraisal lead quality assures inputs to appraisal.

Action for next year:

1. Appraisal lead to present audit of ‘quality of inputs to appraisal’ to the appraisers at the next quarterly appraisers meeting

**6.** The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

1. Review the functioning of RAGG and update the Board in next year’s report

Comments:

Inputs and outputs from Appraisal are quality assured as noted above.

The Board receive an annual report on medical appraisal and revalidation.

We hold a monthly medical appraisal meeting. Membership for this group is the RO, Medical Director, Appraisal Lead, Medical HR advisor and Revalidation Administrator.

The first meeting of our Revalidation & Appraisal Governance Group (RAGG) was held virtually via Microsoft Teams on 3 March 2021 TOR were amended and agreed. We plan to review our performance against the principles in the 'Effective clinical governance for the medical profession' handbook.

Action for next year:

1. Evaluate the functioning and outcomes of RAGG

## Section 3 – Recommendations to the GMC

**1.** Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Action from last year:

1. Review / audit notifications to RO from appraisal and FtP concerns

Comments:

45 doctors have revalidated this year. There have been no late submissions. The RO makes the recommendation directly to the GMC via GMC Connect or PReP IT.

Following a reminder issued by RO to clinical & divisional directors / managers that the MD and RO must be notified if a doctor's contract is terminated early due to concerns about their practice / competence there has been an improvement in such notifications. Appraisers do contact the RO if there is anything from appraisal they need to bring to the attention of the RO.

Potential / actual FtP concerns are discussed at the RO / GMC ELA meetings and in between these as necessary.

**2.** Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Comments:

Doctors are informed of RO recommendations via email to the Doctor at the time of submission via GMC Connect.

Recommendations to defer are discussed with the doctor either face to face or via email well before that recommendation is submitted.

Deferrals may be a joint agreement between Dr and RO depending on the reason for deferral. Reasons for deferral and actions the doctor needs to complete to enable a recommendation to revalidate to be made are set out clearly and provided in writing (usually via email). No recommendations of non-engagement have been submitted this year.

## Section 4 – Medical governance

**1.** This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

1. Reflect on the functioning of RAGG

Comments:

See above regarding first meeting of RAGG held on 3 March 2021. TOR and summary minutes available. RAGG is to meet three times per year.

Clinical governance systems exist from departmental level, through Care Group to Divisional level and the Board supporting an environment to deliver continued improvement in quality and care. The Trust achieved 'Good' overall at the CQC inspection 2018.

Audit, colleague & patient feedback, risk reporting and Duty of Candour are actively promoted. Relevant training is provided in such areas. (GMC handbook Principle 1c)

Lay involvement is apparent on Trust groups and committees. There is an established Junior Doctors Forum with good engagement from chief registrar, Director Medical Education (DME), Guardian of Safe Working as well as junior doctors and senior management including CEO. (GMC handbook Principle 2a)

Learning from our own and external organisations is evident across the Trust in a variety of ways e.g. Mortality & Morbidity meetings; guideline development; clinical and managerial / strategic networks; newsletters. Patient feedback (examples available on wards and from risk management systems / Learning from Incident Panels) is used to improve service development. (GMC handbook Principle 2b).

There is an Introduction to Appraisal & Revalidation programme for new starters. A powerpoint presentation supports overseas doctors information and induction alongside the face to face meeting with the appraisal lead.

**2.** Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Action from last year:

1. Introduce & evaluate the proposed annual review process for consultant & SASG doctors

Comments:

Clinical governance systems are in place. Minor low level issues regarding conduct and performance of doctors are managed at local departmental level with escalation if there is a failure to respond or an increase in level of concern. Datix, with risk management systems, supports recording & investigation of clinical concerns for capability or conduct when a clinical risk has been identified. Information regarding risk events and complaints is provided for and discussed at appraisal.

Plans for consultant & SASG annual review (with their clinical lead and service manager which feeds into their annual appraisal & job planning review) on hold during Pandemic and the 'Culture review' at DCHFT..

Doctors in senior managerial roles (e.g. Divisional Director, Medical and Deputy Medical Directors) already have a performance review as well as an annual appraisal

Action for next year:

1. Revisit whether there is a need for an annual (performance) review for all SASG / Consultants at DCHFT in addition to their annual appraisal and the job planning process currently in existence.

**3.** There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

Comments:

Maintaining High Professional Standards is the approved policy used for responding to concerns.

Fitness to Practice issues are discussed at the RO / MD / GMC ELA meetings which are held regularly. The GMC ELA is available for informal / formal discussion by telephone between face to face meetings.

At the HLROQR it was advised that the Medical Director and Deputy medical director should not routinely be named as case investigator nor manager as they may be required to chair an appeal or disciplinary panel.

**4.** The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year:

1. HR to compile a list of formally trained case investigators and case managers
2. HR (with RO & MD support) Audit of case investigation and management against standards in MHPS and GMC governance handbook
3. Contact neighbouring Designated Bodies (Yeovil, Bournemouth, Poole) to consider sharing of resources for case investigation and management and make links for peer support.

Comments:

HR have a list of trained case investigators and managers.

Audit of case investigation & management not able to be completed as planned due to other HR / RO priorities.

The scheduled Case Investigator training for 30-31 March had to be postponed due to national guidance around Covid-19. We are awaiting new dates or the development of virtual training.

Action for next year:

Carry over actions 2 & 3

**5.** There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Yes

Comments:

MPIT forms (national process) are used. Telephone conversations or virtual meetings via MS Teams have occurred where there were higher level concerns potentially likely to impact on patient safety / outcomes. The use of virtual meetings has been one of the positive outcomes from the pandemic.

**6.** Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Comments:

HR policies include an Equal Opportunities Impact Assessment & statement

Processes could be strengthened by implementing actions in 4 above

## Section 5 – Employment Checks

**1.** A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Comments:

In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT:

Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO.

Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice)

HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body.

GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns.

Information sharing processes adhere to Caldicott principles. RO and MD share the role of Caldicott guardian. . (GMC handbook Principles 4e & f).

## Section 6 – Summary of comments, and overall conclusion

**See Action Plan at Appendix E**

**Overall conclusion:**

**The Trust continues to meet all statutory duties in relation to medical revalidation & RO regulations.**

**We continue to monitor appraisal rates. Appraisal rates locally and nationally will have been impacted by Covid-19 and national recommendations. The Appraisal 2020 template has been welcomed by those doctors using this as there has been more emphasis on well-being, support and development than on collating data and paperwork.**

**Divisions still need to be mindful of the need to put forward suitable candidates to take on the role of medical appraisal. We are also reviewing appraisal processes for locally employed doctors (LED) with the aim of making appraisal less onerous and more supportive. By the proposal to mirror ARCP we also hope to reduce the burden on our systems for finding sufficient numbers of appropriately trained and confident appraisers for LED.**

**The introduction of a Revalidation & Appraisal Governance Group we hope will support Board level accountability for quality of medical appraisal.**

**The GMC Regional Liaison Service offers training to support Revalidation and may be something the Board would wish to consider for one of their development days. (GMC Handbook Principle 1a)**

## Section 7 – Statement of Compliance:

The Board of Dorset County Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[Chief executive or chairman]

Official name of designated body: Dorset County Hospital NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _

# Update of appraisals for 20/21 appraisal year

**Name of Organisation: Dorset County Hospital**

**Total number of appraisals which were due to take place 20/21 appraisal year 269**

**Total number of appraisals which took place 187**

**Total number of appraisals recorded as approved missed due to COVID 76**

**Do you offer your doctors the input light appraisal template? Yes**

AOA Monthly Report 2020/21 Current ( 228 ) Amended as at 22/06/2021 and supersedes previous version

Report March 2021 Leavers (41 ) Total (269 )

| Doctors with whom the designated body has a prescribed connection. | | No of Prescribed connections | Completed appraisals (1) | Optional Completed appraisals (1a) | Approved incomplete or missed appraisals (2) | Unapproved incomplete or missed appraisals (3) | Total |
|---|---|---|---|---|---|---|---|
| **Consultants** (Permanent employed consultant medical staff including honorary contract holders, NHS, hospices and government/other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS Trust where they perform their clinical work. ) | | 139+6=145 | 110+2=112 (77.24%) | **30+1= 31** | 29+4=33 (22.76%) | 0+0=0 | 139+6=145 |
| **Staff Grade, associate specialist, specialty doctors** (Permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff. | | 40+13=53 | 30+5=35 (66.04%) | **7+3= 10** | 10+8=18 (33.96%) | 0+0=0 | 40+13=53 |
| **Doctors on Performers Lists** (for NHS England and the Armed Forces only. Doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs) | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Doctors with Practising Privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade). | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Temporary or short-term contract holders** (temporary employed staff including locums who are directly empl0yed, Trust Doctors, Locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc. ) | Cons | 11+5=16 | 10+2=12 (75%) | **2+0= 2** | 1+3=4 (25%) | 0+0=0 | 11+5=16 |
| | Spec | 7+4=11 | 5+3=8 (72.73%) | **3+1= 4** | 2+1=3 (27.27%) | 0+0=0 | 7+4=11 |
| | Trust | 31+13=44 | 14+6=20 (44.45%) | **11+4= 15** | 17+7=24 (54.55%) | 0+0=0 | 31+13=44 |
| **Other Doctors with a prescribed connection this this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc.) | | | | | | | |
| **TOTAL** | | 228+41=269 | 169+18=187 (69.52%) | **53+9= 62** | 59+23=82 (30.48%) | 0+0=0 | 228+41=269 |

# Revalidation ACTION PLAN

| Area for development for DCHFT as RO service provider | Action | Responsibility | Timescale | Assurance | Progress (as at June 2021) |
|---|---|---|---|---|---|
| 1. Improve appraisal rates (in line with peers) | i) Liaison with DD's, CD's and DM's to identify potential appraisers with agreed remuneration & resourced time for appraisers.<br>ii) Meeting to be scheduled between RO / MD and Director of HR / Deputy Director HR to discuss contract for doctors at DCHFT (relating to appraisal requirements)<br>iii) Review arrangements for acceptance of a prescribed connection and appraisal scheduling for short term contract / As &When Drs<br>iv) Liaison with Care Group leads to improve their | RO with DD & DM<br>RO / MD / Director HR<br>RO / Revalidation administrator with HR advisor<br>Appraisal Lead / CDs and service managers with HR admin support | i)Quarterly monitoring in line with NHSE returns<br>ii)Complete<br>iii)Complete<br>iv)Partially complete as some departmental monitoring of appraisal rates include medical staff. Revised date Dec2021 | Appraiser to doctor ratio nearer 1:6<br>Improving appraisal rates | i)Liaison with DD's & DM's ongoing to try to recruit more appraisers.<br>New appraisers have undertaken training, however a similar number of appraisers have relinquished this role.<br>Business case for LEDs 'ARCP' Panel & access to ES/ CS<br>ii &iii)Meeting held and medical appraisal & revalidation policy updated.<br>Discussions affirmed the contractual requirement for annual appraisal. No agreement or decision to take forward at DCHFT at this time the action implemented at some other |

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|---|---|---|---|---|---|---|
| | | monitoring of medical appraisal rates – with proposal to introduce RAG table | | | | Trusts to withhold pay if appraisal not completed within 28 days of appraisal anniversary.<br>iv)To be scheduled |
| 2. Strengthening the clinical governance and QA arrangements for locum and As & When contract holders | i)<br><br><br><br>ii)<br><br><br><br><br><br><br>iii) | Appraisal lead with RO and HR to explore the use of locum exit forms.<br>Introduce requirement for contract holder to meet with clinical lead and engage in local educational and clinical governance programme- e.g. via 'contract of expectations'<br>Review of contract to consider introduction of a minimum period of work per 6 or 12 month contract to support revalidation | i) RO & Appraisal lead making enquiries within Regional RO network.<br>ii) DD's and DM's with CD's / clinical leads<br>iii) HR (deputy director and medical HR advisor) | i) Oct 2019- Partially complete; revised date June 2021<br>ii) Oct 2019- Partially complete; revised date June 2021<br>iii)Jan 2020- completed | Locum exit form in use<br>Agreed & signed contract of expectations at start of post<br>Attendance records at educational / CG sessions<br><br><br>Employment contract update<br><br>Medical Appraisal & Revalidation Policy | MPIT generally RO to RO whereas we would like a form signed by a consultant or clinical supervisor that the locum can use within their portfolio. MPIT to be used if significant concerns arise.<br>Awaiting template locum exit forms from NHSE/I- not received thus need to consider in house development. Likely to adapt the scope of practice forms for use.<br>ii) Contract of Expectation to be drawn up. Discussion held at Quarterly Appraiser |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | meeting. Requires reminder at Care Group CG meetings to embed<br><br>iii)Updated medical appraisal & revalidation policy complete |
| Strengthen the governance & QA processes for appraisal & Revalidation | Introduction of a Revalidation & Appraisal Governance Group (RAGG)at DCHFT.<br>TOR for such groups available via Regional network. | RO with Board / HR support | Jan 2020<br>Partially complete; revised date Dec 2020 | RAGG TOR / minutes | RO & Exec team agreed expenses reimbursement for lay member.<br>TOR written.<br>First quorate meeting held 3 March 2021. |
| Consider how to improve the QA of case investigation and peer support to case investigators and case managers when responding to concerns about doctors | i) Review the QA processes & support for case investigation & management in place at DCHFT<br>ii) Compile a list of trained case investigators and managers<br>iii) Liaise with neighbouring RO to determine interest in sharing resources and peer support | Deputy Director HR<br><br>RO | June 2020<br>Partially complete; revised date June 2021 | Audit of case investigation & management<br><br>Buy in to NHS Resolution (PPAS) resources | HR team compiling list of trained case investigators & case managers<br><br>The Trust had commissioned PPA (formally NCAS) to provide some onsite Case Investigator training in March 2020. Training postponed due to Coronavirus. Awaiting new date. 2 staff attended UHD |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | training.<br>To formulate audit of case investigation & management against MHPS |
| **I confirm that the action plan above has been discussed and agreed with my Board or equivalent** | | *Responsible officer - Signature & Date* | | | |

| | |
|---|---|
| **Meeting Title:** | Board Meeting |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | **Maternity Safety Report July 2021** |
| **Responsible Director:** | Nicky Lucey, Chief Nursing Officer |
| **Author:** | Jo Hartley, Head of Midwifery |

| | |
|---|---|
| **Confidentiality:** | *If Confidential please state rationale:* |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Quality Committee | 20th July 2021 | |
| | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | *This section is to assist the Board / Committee to understand the reasons why the paper is being presented and what you are asking the Board / Committee to do.* | | | | | | | |
| | *Note (✓)* | ✓ | *Discuss* | | *Recommend* | | *Approve (✓)* | ✓ |
| **Summary of Key Issues** | This report sets out to the Trust Board, the quality and safety activity covering the month of June and where relevant, quarter one. This is to provide assurances of maternity quality and safety and the effectiveness of patient care with evidence of quality improvements.<br><br>• Maternity staffing remains challenging with increased sickness and absence for bereavements and caring responsibilities noted. We are currently awaiting confirmation of the allocated funding from NHSE to increase the midwifery establishment<br>• Increasing numbers of women booked for induction of labour is putting pressure on capacity and workforce. This reflects the national picture and has been raised with the Chief Midwifery Officer<br>• No new cases referred to HSIB<br>• No new cases for the Perinatal Mortality Review Meeting<br>• Ockenden evidence submitted<br>• Maternity Incentive Scheme evidence completed and awaiting submission<br>• An additional risk has been added to the risk register relating to lack of clinic space for women requiring support for the mental health during pregnancy – current wait times are into the Autumn<br>• MDT training numbers improving for obstetric emergencies but extra sessions arranged to ensure target met. Number of midwives and obstetricians who have completed K2 fetal monitoring training is >90% | | | | | | | |
| **Action recommended** | The Trust Board is recommended to:<br><br>1. **NOTE** the report<br>2. **APPROVE** the contents | | | | | | | |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | Y | Safety and quality in maternity services remains very high on the national agenda with several Trusts receiving critical CQC reports in the last few months and others under national scrutiny |
| **Financial** | Y | The refund of 10% of the CNST Incentive Scheme, if awarded will be assigned to the Maternity budget with a focus on improving safety |
| **Impacts Strategic Objectives?** | Y/N | *If yes, please state positive and / or negative impact* |
| **Risk?** | Y | Current risks for maternity are outlined in the report |
| **Decision to be made?** | N | |
| **Impacts CQC Standards?** | Y | As above |
| **Impacts Social Value ambitions?** | Y/N | *If yes, please state* |
| **Equality Impact Assessment?** | Y/N | *If yes include as an appendix to the report and note here* |
| **Quality Impact Assessment?** | Y/N | *If yes include as an appendix to the report and note here* |

Dorset County Hospital
NHS Foundation Trust

# Maternity Quality and Safety report

July 2021

Submitted by Jo Hartley, Associate Director of Midwifery & Neonatal Services

Executive sponsor: Nicky Lucey, CNO

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## Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of June and where relevant, quarter one. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Maternity staffing remains challenging with increased sickness and absence for bereavements and caring responsibilities noted
- Increasing numbers of women booked for induction of labour is putting pressure on capacity and workforce
- No new cases referred to HSIB
- No new cases for the Perinatal Mortality Review Meeting
- Ockenden evidence submitted
- Maternity Incentive Scheme evidence completed and awaiting submission
- An additional risk has been added to the risk register relating to lack of clinic space for women requiring support for the mental health during pregnancy – current wait times are into the Autumn
- MDT training numbers improving for obstetric emergencies. >90% for K2 fetal monitoring training completed

## Section 1: Activity and incidents reported.

### 1.1 Activity as of the end of the first quarter April- June 2021

Bookings - 403
ANDA attendances - tbc
Planned caesareans – 12%
Emergency caesareans - 23%
Women who smoked at booking – 14%
Initiating breastfeeding – 75%

Babies admitted to SCBU at term – 32
Total births – 389
Inductions - 37%
Births at home – 8%
Women who smoked at birth – 10%

### 1.2 DCH reported incidences

**Dorset County Hospital** reported Maternity Patient Safety incidents from June 2020 to May 2021 using data collated from Datix Web Electronic Reporting Systems.

### Total Number of Incidents for June 2020 to May 2021:

| July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | April | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 60 | 60 | 75 | 63 | 54 | 49 | 54 | 72 | 50 | 52 | 50 | 60 |

**Red Flag incidents:** A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Initially, DCH Maternity initially (and for some months) utilized an Acuity App to collect red flag data, but this platform was not suitable for our service, so the data is now collected via Datix.

| Red flag | Descriptor | Incidence |
|---|---|---|
| RF1 | Escalation to divert of maternity services | 0 |
| RF2 | Missed medication | <5 |
| RF3 | Delay in providing or reviewing an epidural in labour | 0 |
| RF4 | Delay of more than 30 minutes between arrival and admission in ANDAU - | 8 |

| | | |
|---|---|---|
| RF5 | Full clinical examination not carried out when presenting in labour | 0 |
| RF6 | Delay of ≥2 hours between admission for induction of labour & starting process | 0 |
| RF7 | Delay in continuing the process of induction of labour | <5 |
| RF8 | Unable to provide 1 to 1 care in labour | 0 |
| RF9 | Unable to facilitate homebirth | <5 |
| RF10 | Delay of time critical activity | 8 |

RF10 6 of the delays in time critical activity relates to the lack of appointments for the Peirnatal Mental Health service. This is a consultant led clinic and the next appointments are in the Autumn. Women continue under the care of their midwife but the specialist input and care planning is not available, sometimes until the woman is almost at the end of her pregnancy.
RF4 The delayed activity relates to Induction of labour (IOL). Given the increasing rates of IOL, delays in the procedure will continue. Cases are assessed individually when a delay is anticipated, by the coordinator and the consultant obstetrician and the woman is informed of the delay, with apologies. This problem will inevitably happen more frequently following the NICE draft guidance that IOL are offered at term plus 7 days, instead of currently at term plus 12-14 days. UHD also experience similar challenges.
RF4 The delay in admission to the ANDAU reflects the increasing workload and lack of bed space. Overall, ANDAU is well staffed with two midwives and a maternity support worker (MSW). Sometimes there are delays in discharging women whilst they wait for an obstetric review. Waiting times are currently being audited. The obstetric team now attend ANDAU after ward round (as well as when requied throughoutthe day)

## 1.3 Incidents 6 Months by Severity of Harm

| Severity | January | February | March | April | May | June |
|---|---|---|---|---|---|---|
| Risk still open | | | | | | 16 |
| No Harm | 71 | 45 | 46 | 45 | 57 | 40 |
| Low | <5 | 5 | 6 | 5 | <5 | <5 |
| Moderate | 0 | 0 | 0 | 0 | 0 | 0 |
| Severe | 0 | 0 | 0 | 0 | 0 | 0 |
| Death | 0 | 0 | 0 | 0 | 0 | 0 |

## 1.5 Health and Safety incidents:

**Nothing to report**

## 1.6 Medication incidents

### Medication Incidents:

| Category | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|
| Administration: Duplication | <5 | - | - | - | - | - |
| Administration: Missed or delayed medication | - | <5 | <5 | <5 | <5 | <5 |
| Administration: Wrong dose | - | <5 | - | <5 | - | - |
| Prescribing: drug choice inappropriate | <5 | - | - | - | <5 | - |
| Prescribing: Missed or Delayed | <5 | <5 | - | - | - | - |
| Storage/Security: Medicine left unattended | - | - | - | - | - | <5 |
| 5 | <5 | 5 | <5 | <5 | <5 | <5 |

## Severity of Medication Incidents:

| Severity | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|
| No Harm / Near Miss | <5 | 5 | <5 | <5 | <5 | <5 |
| Low | <5 | - | - | - | <5 | - |
| Moderate or Above | - | - | - | - | - | - |
| **Total** | <5 | **5** | <5 | <5 | <5 | <5 |

## 2.1 Highlights: Risk Register

| ID | Title | Risk Statement | Open | Review | Risk 05/0 | Risk Level |
|---|---|---|---|---|---|---|
| **859** | Antenatal Day Assessment facilities | ANDAU has only three beds - its capacity is limited which in turn impacts on the quality of the service provided<br>Update May 2021: currently using one of the labour rooms to see patients. Funding being explored to relocate ANDAU to a larger room | 18/12/2019 | 04/03/2021 | High Risk | Care Group |
| **871** | Levels of Entonox Exposure on the maternity unit | Update May 2021: modifications of rooms complete. Reassessment of levels now underway | 24/12/2019 | 02/06/2021 | High Risk | Care Group |
| **876** | Maternity Staffing | Birth rate Plus audit completed April 2021– 10.5 W.T.E midwives required.<br>Update May 2021: awaiting to hear whether funding secured from central budget for maternity services | 24/12/2019 | 02/05/2021 | High risk | Care Group |
| **1043** | Gynaecology/ obstetric middle grade rota | July 2021. the situation remains challenging with ongoing reliance on locums and consultants acting down to fill short-term vacancies caused by sickness. One new middle grade recruited - a very successful appointment. Another joining soon but still not fully staffed and one doctor pregnant and requiring adjustments to her rota. | 22/03/2016 | 05/07/2021 | High risk | Division |
| **1121** | Lack of appointments for the perinatal mental health consultant clinic | Escalating numbers of women requiring referral to the perinatal mental health service. | 05/07/2021 | 01/10/2021 | High risk | Division |

## 3.1 Complaints

| Month | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Formal | <5 | 5 | <5 | <5 | <5 | <5 | <5 | <5 | 0 | <5 | 0 | <5 |
| Informal | <5 | 0 | 0 | 0 | <5 | <5 | <5 | <5 | 0 | 0 | 0 | 0 |
| Total | <5 | 5 | <5 | <5 | 5 | 6 | <5 | 6 | 0 | <5 | 0 | <5 |

### Details of themes in complaints and PALS

One of the three complaints received in June was erroneously added into May. The key themes are support provided to women in the latent phase of labour (see May's report for more detail) and gaining explicit consent for all procedures and examinations. The issue of consent focuses on doctors and one of the complaints focuses on the behavior of a locum middle grade obstetrician. This is being addressed with the individuals concerned (as well as the locum doctor's agency) and in Clinical Governance meetings, the newsletter and the Consultant meeting

### Mortality, Morbidity, Serious Investigations, External Reporting & Learning

## 4.1 Mortality MBRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases

### Stillbirths for quarter one, April-June 2021

| Ref | Description |
|---|---|
| | No stillbirths reported |

### Neonatal Deaths for quarter one, April – June 2021

| Ref | Description |
|---|---|
| | No neonatal deaths reported |

## 4.2 Perinatal mortality reviews

**Perinatal Mortality Review panel**

Next meeting scheduled for 24th June 2021

**Cases pending review at Perinatal Mortality Review panel as of date of report**

| | |
|---|---|
| Number of cases pending initial review at PMR panel | **0** |
| No of cases awaiting pending PM/final review/review closure | 0 |
| **TOTAL cases requiring review completion** | 0 |

## 4.3 Morbidity including M&M meetings

No incidents reported in March 2021 of term live babies requiring cooling, meeting RCOG EBC criteria and reporting to NHS Resolution.

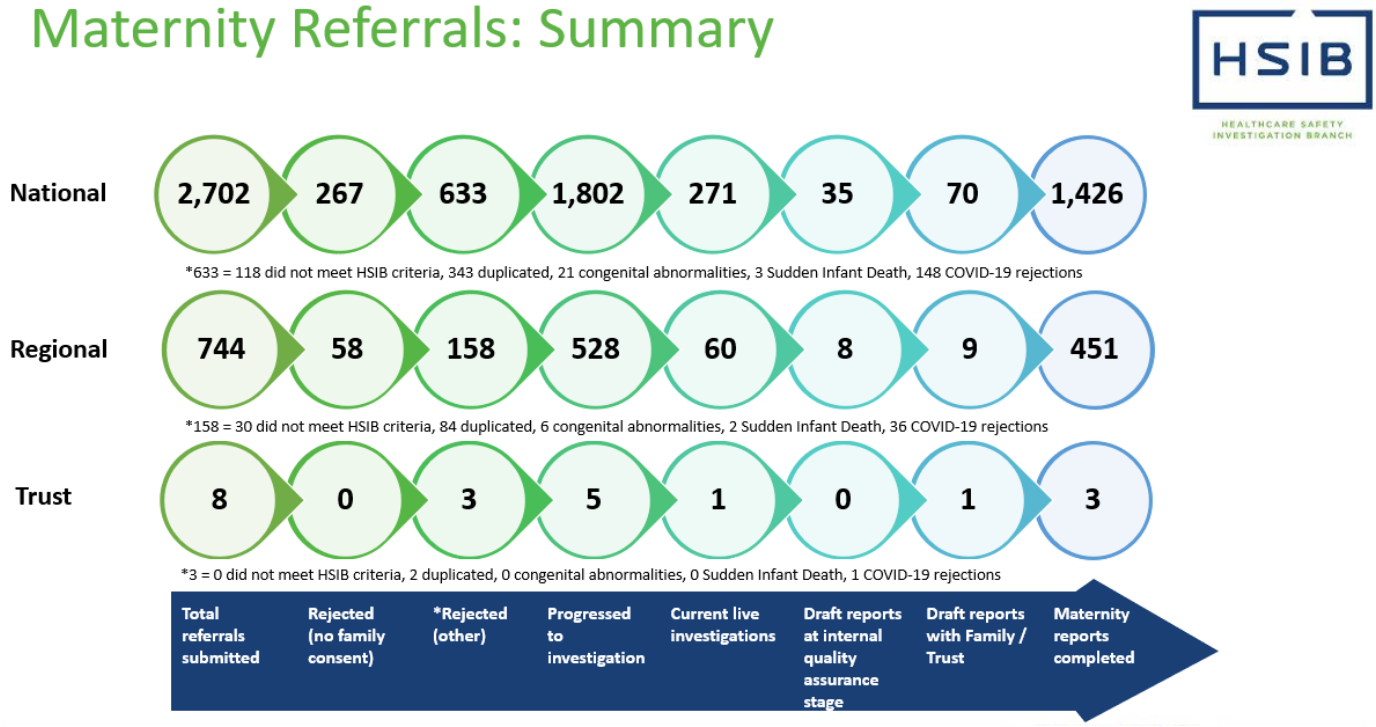
**Mortality and Morbidity – multi professional with maternity, obstetrics and neonatal - June 2021**

| **Categorisation of contributing factors as agreed by M&M group:** |
|---|
| **Obstetric Learning**<br>• **Case one**.<br>• To ensure senior midwives/obstetric team escalate to 2nd or 3rd anaesthetist oncall in an emergency.<br>• Funding for extra anaesthetic middle grade in ITU will help in the future.<br>• **Case two.**<br>• MgSO4 needs to be given to all women if a premature birth is suspected or inevitable<br>• Periprem bundle – can we use this concept to help us get better at managing preterm births. This requires further discussion as designed more specifically for maternity services with level 2 or 3 neonatal units<br>• The fetal monitoring lead to discuss case with DAU as there is learning regarding escalation of poor CTGs.<br><br>**Paediatric Learning**<br>• Ensure careful consideration of antibiotic stewardship for babies on SCBU – if no evidence for infection then stop antibiotics<br>• Timely repatriation from LNU/NICUs remains an issue and has been raised at regional level. Datix being submitted on each occasion. |
| Choose an item. |
| Preventable harm: no |
| Further investigation required: no |
| Is the formal duty of candour being triggered: no |
| Any additional comments: |

## 4.4 further maternity learning

## 2.4 HSIB quarterly review meeting

The only change is that all reports have been complete now




## Section 3:Reports and national guidance

### 3.1 Progress against relevant reports and guidance

**HSIB national thematic review: Big Babies** - Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia https://www.hsib.org.uk/investigations-cases/severe-brain-injury-early-neonatal-death-and-intrapartum-stillbirth-associated-larger-babies-and-shoulder-dystocia/

**NICE guidance requiring evaluation:**
NG192 – caesarean birth
NG194 – postnatal care
QS22 – antenatal care

Currently benchmarking DCH Maternity service against recently published CQC reports whee maternity services have been down-graded

## Section 4: Safety Champions action plan

### 4.1 Action Plan

| Minute | Action | Timescale | Outcome |
|---|---|---|---|
| 1 | Staffing Levels | Staff meeting June 2021. | Reduced staffing and increased acuity has led to escalation to divert. CCG informed on both occasions. Jo Hartley to discuss plans for staffing the maternity unit, how the SMT review staffing and the reduction of central funding for staff. Awaiting funding confirmation from NHSE |
| 2 | Staff orientation | May 2021 | Thought to be an isolated incident. Process in place to support new doctors (substantive and locum) Staff will continue to monitor. |
| 3 | NRFit. To prevent medication errors different fittings are being sourced. | July 2021 | New fittings under review. Once equipment has been received by the Trust, the obstetric anaesthetists will roll out education and training |
| 4 | Lateral flow testing | Completed | Embedded within the service. |
| 5 | Paediatric staffing over August for staff induction | Completed | Robust plan in place for induction period. |
| 6 | Terbutaline PGD | July 2021 (medicines committee) | Now signed off and training commencing – starting with the homebirth team |

## Section 5: Service User Feedback

### 5.1 debrief feedback

**Action: Learning on incidents has been shared with midwives about ensuring that implications of actions are explained to women. Continued focus on the vital importance of gaining consent for any procedure or intervention and ensuring that alternatives are also discussed.**

### 5.2 Maternity Voice Partnership

- A survey is being undertaken to evaluate our maternity Matters Website from service users

## Section 6: Training

| Training | Staff grade | Percentage of attendance |
|---|---|---|
| PROMPT (Practical Obstetric Emergency Procedure Training) | Obstetric Anaesthetists | 79% |
| | Obstetric Consultants | 75% |
| | Doctors (Reg/SHO) | 58% |
| | Midwives | 79% |
| | MSW | 31% |
| BLS | Obstetric Anaesthetists | 89.5% |
| | Obstetric Consultants | 100% |
| | Doctors (Reg/SHO) | 100% |
| | Midwives | 94% |
| | MSW | 97% |
| NLS (4 yearly accredited course) | Senior Midwives/Homebirth Midwives | 95% |
| NLS (yearly update) | Midwives | 91% |
| K2 Fetal Monitoring | Doctors (All grades) | 93% |
| | Midwives | 98% |

Obstetric doctors' attendance has improved. Only one doctor not attended and one consultant not attended. Extra sessions scheduled.

Practical Obstetric Emergency Procedure Training (PROMPT) is held monthly for the Multidisciplinary Team on the maternity unit, DCH. This is a mandatory, yearly training run by 2 practice development midwives, 3 supporting midwives, anaesthetists, an obstetric consultant, a resusitation simulation trainer and ana advanced neonatal nurse practitioner.

PROMPT faculty meetings occur 3 monthly to review feedback, changes in local and national guidance in line with NICE and RCOG and review effectiveness of training. Adaption of presentations, format and scenarios is ongoing to provide up to date, evidence based research and guidance alongside local risk reviews and learning outcomes

.

Minutes of the meeting and actions identified to be shared within the team and Associate Director of Midwifery & Neonatal Services. Attendance is updated on the education training matrix monthly and uptake reported to the LMS.

## Section 7: Maternity and medical staffing

### Maternity Staffing

**This report is in the process of being finalised**

## Section 8: Maternity incentive scheme Year 3

Evidence template completed

## Section 9: Ockenden Actions

**Evidence portal**

Evidence submitted to the portal as required

| Immediate and essential action | Action required |
|---|---|
| **Enhanced safety** | Additions to maternity risk strategy required - completed<br>HSIB reports<br>SI reports<br>Minutes for LMNS safety meeting & partnership meeting<br>Reviewing the maternal death guideline – new guideline completed |
| **Listening to women and their families** | Submission from th LMNS about the MVP<br>Addition to Babyloss guidance to include clear reference to the perintal mortiality review process - completed |
| **Staff training and MDT** | Audit of consultant attending for ward rounds - ongoing<br>Attendence at MDT training – see above. Submission of last 18 months attendence to take into account pandemic restictions. |
| **Managing complex pregnancy** | Review pathway for referral to tertiary centre - completed |
| **Risk assessment during pregnancy** | Risk assessment during pregnancy – new proforma being trialed<br>Evidence of complex care planning as required – individual cases |
| **Monitoring fetal wellbeing** | Evidence of rostered time for the consultant and midwife leads |
| **Informed consent** | Review the website Maternity Matters with service users<br>Particular focus on caesarean for maternal request – well supported by DCH<br>SOP for women who choose to birth outside guidelines |
| **Saving Babies Lives Care Bundle** | References throughout the evidence required. DCH is compliant with all five standards but several audits have been identiifed |
| **Management of NICE Guidance** | Trust guideline submitted but Maternity specific guideline will be required |

## Section 10 : Quality improvements/maternity transformation

**Maternity transformation highlights**

**Maternity transformation continues. New highlights from these workstreams are highlighted below:**

- Initiation of “Safety Boxes” on the maternitty unit to encourage staff to post any concerns. The contents will be reviewed by the Safety Champions chaired by the CNO
- Large display boards detailing the Safety Champions for the maternity unit
- Large display board for Clinical Governance, you said/we did for patients and staff, learning from incidents etc. for the maternity unit
- CNO shadowing the maternity coordinator
- Impovement to perinatal mental health service with external funding for a midwife/psychotherapist
- Implementation planning has started or the PAN Dorset Digital system with the first site DCH due to go live in July 2021. UHD to follow in October.
- Labour Line business case for recurrent funding have been submitted through the Dorset prioritisation process and other actions being explored for ‘quick wins’ to improve safety. Labour line project to implement ‘quick wins’ including a new overflow process.
  Funding from NHS halted until July so prioritisation also suspended at present.Interim solution to reduce risk being discussed. Labour line project to implement ‘quick wins’ including a new overflow process
- Translation tool is being explored to add to Maternity Matters website to translation and easy read of all content
- BAME pathway published
- UNICEF Baby Friendly compliance commenced
- MVPs in roles and engaging well with maternity units and service users. Very active social media.
- MSW transformation progressing – workforce competencies mapped
- Ockenden report – progressing
- Application to be an early implementor for postnatal physiotherapy has been successful
- Continuity of care has achieved 30%
- LMS safety meetings established – second meeting successfully completed
- Maternity dashboard – work continuing to produce a dashboard more reflective of current KPIs but unfortnately, progress is slow

| | |
|---|---|
| **Meeting Title:** | Board of Directors Part One Meeting |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | Maternity Incentive Scheme (MIS) |
| **Responsible Director:** | Nicky Lucey, Chief Nursing Officer |
| **Author:** | Jo Hartley, Associate Director of Midwifery & Neonatal Services |

| | |
|---|---|
| **Confidentiality:** | No |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Quality Committee | 18 May 2021 (within Maternity Report) | |
| Quality Committee | 22 June 2021 | Recommended to Board |
| Board of Directors | 30 June 2021 | Approved for submission outside the meeting. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | | | | | | | | |
| | *Note (✓)* | | *Discuss (✓)* | | *Recommend (✓)* | | *Approve (✓)* | To ratify |
| **Summary of Key Issues** | For the third year, NHS Resolution is running the Clinical Negligence Scheme for Trusts (CNST). Trusts that can demonstrate they have achieved all ten maternity safety actions will recover the element of their contribution to the CNST maternity incentive fund (£146,644 for DCH in the second year of the scheme) and will receive a share of any additional unallocated funds.<br><br>There are ten safety standards to be achieved<br>• Use of the perinatal mortality tool to review perinatal deaths<br>• Submission of data to the Maternity Data Set<br>• Demonstrate we have a transitional care pathway and we activity engage with ATAIN (avoiding term admissions into the neonatal service)<br>• An effective system of clinical workforce planning<br>• An effective system of midwifery workforce planning<br>• Compliance with all five elements of the Saving Babies Lives care Bundle<br>• Working with the Maternity Voices Partnership (MVP)<br>• In house training<br>• Safety champions<br>• Early notification scheme<br>If the Trust achieves this incentive the national requirement is that the savings are re-invested into the maternity services to support the Ockenden action plan, including safe staffing gaps potentially not funded by the national funding stream.<br><br>Due to the lateness of the national timelines Quality Committee have been delegated to scrutinize and suggest any final amendments that recommend to the Board the submission of the national deadline of the 15th July. | | | | | | | |
| **Action recommended** | The Board of Directors is asked to ratify their decision to approve for submission taken outside the meeting on 30 June 2021. | | | | | | | |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | Y | MIS is a national scheme to incentivize trusts to improve the safety of their maternity services |
| **Financial** | Y | There is a financial incentive to meet all the actions. However several actions require financial support to succeed |
| **Impacts Strategic Objectives?** | Y | **C**ollaborative – ensuring the voce of the patient (the woman) is central to care provision and to safety<br>**O**utstanding – the MIS provides a framework in which to provide outstanding care to women and their families<br>**S**ustainable – the BR+ safe staffing audit will underpin the sustainability of the maternity service alongside the focus on multi-professional training and transparency from floor to Board through the safety champions<br>**I**ntegrated – the safety and quality of the maternity service must be integrated into the Board, the LMS and the ICS<br>**E**nabling – Completing all the actions will ensure the workforce feel confident and proud of the maternity service they represent and the care they provide. Improving access to the safety champions will provide reassurance that al are empowered to speak out |
| **Risk?** | Y | The MIS requires a commitment from the Trust to meet all actions. Any actions not completed will directly affect the way in which the maternity service is viewed and evaluated locally, regionally and nationally. |
| **Decision to be made?** | Y | Requirement to agree to national submission |
| **Impacts CQC Standards?** | Y | The report links to all five domains |
| **Impacts Social Value ambitions?** | N | |
| **Equality Impact Assessment?** | N | |
| **Quality Impact Assessment?** | N | |

Dorset County Hospital NHS
NHS Foundation Trust

# Maternity Incentive Scheme CNST

## 1. INTRODUCTION

1.1 NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

1.2 As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNST MIS contributions were not taken in April 2020 as would otherwise have occurred.

1.3 DCH has successfully met all ten safety actions in Year 2 of the scheme and secured a rebate of £146k

## 2. FORMAL VALIDATION PROCESS

2.1 Trusts are expected to provide a report to their Board (this Report) demonstrating achievement, with evidence, of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for submission.

2.2 The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's Chief Executive. If the form is signed by another Trust member this will not be considered.

2.3 It should be noted that Trusts do not need to submit the report or any evidence to NHS Resolution. NHS Resolution will use external data sources to validate some of the Trust's responses.

2.4 Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution by 12 noon on Thursday 15 July 2021.

## 3. ACTION REQUIRED

3.1 The evidence to meet the Safer Standards for Maternity Care has been put forward, reviewed and approved by the Chief Nursing Officer. The Board of Directors is now asked to self-certify the Trust is compliant to the ten standards based on the Safer Standards for Maternity Care.

3.2 The same evidence and report has been shared with and approved by Dorset NHS Commissioners.

Board Report on Dorset County Hospital's progress against the Maternity Incentive Scheme maternity safety actions
Date: June 2021
Further information about the MIS including the technical guidance, can be found at www.resolution.nhs.uk

## 4 MAIN REPORT – EVIDENCE OF ACHIEVING THE 10 SAFETY ACTIONS

| **Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | Met Y/N |
|---|---|
| **Required Standard:**<br>a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.<br>ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021<br>b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool<br>c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.<br>**d)** i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion. | |
| **Trust's Commentary and Evidence**<br>• The Trust is using the National Perinatal Mortality Review Tool (PMRT) which became available from the Department of Health in February 2018. The tool is used to review all perinatal deaths from 22+0 gestation to 28 days after birth as well as babies who die after 28 days following neonatal care. The tool was developed to ensure a national standardized approach and high quality reviews across England, Scotland and Wales.<br>• All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.<br>• A review using the Perinatal Mortality Review Tool (PMRT) of 100% of all deaths of babies, suitable for review using the PMRT, has happened. The meeting is multi-disciplinary and includes representation from our neighbouring trust in the LMS. For all cases the dedicated Bereavement Midwife will contact parents to ensure that any questions from them are and incorporate their views to the review. Parents are always made aware of the review<br>PMRT is discussed at the M&M meetings which are MDT with local action plans created for each case as required. If required, cases are escalated to the LMS Safety Meeting. Cases are reported via The Quality Committee. | **Yes** |

| **Safety action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | Met Y/N |
|---|---|
| **Required Standard:**<br>This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. | |
| **Trust's Commentary and Evidence**<br>The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, maternity care plan, care activity, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests.<br>The MSDS at DCH has been submitted in line with required standards and deadlines for December 2020 or January 2021 | **Yes** |

| **Safety action 3**: Can you demonstratethat you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units programme? | Met Y/N |
|---|---|
| **Required Standard:**<br>A) B) C) – standards were removed because of the COVID pandemic.<br>Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.<br>A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to increase in admissions including those for jaundice, weight loss and poor feeding.<br>An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.<br>Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions. | |
| **Trust's Commentary and Evidence**<br>D) The commissioners extract required information from Badgernet straight and have confirmed it meets their requirements. Confirmation email embedded.<br>) An audit trail is available which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken<br>E) An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews<br>• Ongoing audit of all unexpected term admissions involving a midwife, an advanced neonatal nurse practitioner, a paediatric consultant and an obstetric consultant<br>• . Attendance of neonatal safety champion at meetings with CNO<br>• NHS England ATAIN proforma used to look at whether the admission was avoidable or not avoidable.<br>• Team drive for ATAIN that includes database of all reviews and outcomes.<br>• Data for all term readmissions less than 28 days reviewed by postnatal lead midwife as required. Infants readmitted with feeding issues, weight loss and jaundice to be reviewed by infant feeding team and community.<br>G) Demonstrate that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated.<br>• Weekly, documented ATAIN reviews taking place<br>• Info graphic regarding thermoregulation on display for staff<br>• Planning to implement kaiser permanente neonatal sepsis calculator | YES |

| **Safety action 4**: Can you demonstrate an effective system of clinical* workforce planning to the required standard? | Met Y/N |
|---|---|
| Required Standard:<br>Obstetric medical workforce: removed due to pandemic restrictions<br>Anaesthetic medical workforce: an action plan in place to meet standards 1.7.2.5, 1.7.2.1. However DCH is accredited ACSA<br>Neonatal medical workforce: The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level<br>Neonatal nursing workforce: The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations | |
| **Trust's Commentary and Evidence**<br>**Anaesthetic Medical workforce:**<br>1.7.2.5: Our Trust does not run any dedicated elective caesarean lists, elective cases are undertaken in-between emergency cases. Elective cases are undertaken in our sole obstetric operating theatre; therefore have potential to be significantly delayed by emergency cases. However, there is always access to a second theatre (in Main Theatres) should two caesareans be required simultaneously<br>1.7.2.1: The recommendation upon which this is based clearly states that the immediately available duty anaesthetist should not undertake any elective work during the duty period, but in-hours it is usually the same anaesthetist; out of hours there is no elective activity. At DCH 40% of the time there are two anaesthetists allocated for obstetrics to cover elective work and emergency work. Increased recruitment will increase this figure. However there is always asecond anaesthetist available 24/7 as requred<br>**Neonatal Medical Workforce:**<br>The current BAPM (2014) standards for junior medical staffing are met with dedicated 24/7 tier 1 and tier 2 support, supported by ANNPs during the daytime.<br>**Neonatal Nursing Workforce:**<br>DCH meets the current recommendation from BAPM, assessed using the Dinnings Tool | YES |

| **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Met Y/N |
|---|---|
| **Required Standard:**<br>a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.<br>b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service<br>c) All women in active labour receive one-to-one midwifery care<br>d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021) | |
| **Trust's Commentary and Evidence**<br>The National Maternity Review, Better Births, a five year forward view (2016) called for care to become safer and more personalised, focusing on workforce as a core factor in achieving this.<br>Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. By working with individual trusts to understand their activity, case mix, demographics and skill mix Birthrate Plus® can calculate an individual ratio of clinical midwives to births for maternity services. The Trust has recently completed a Birthrate Plus® audit with a recommendation of an increase in WTE midwives. Currently awaiting a decision on funding from NHSE<br>Maternity Co-ordinations have supernumerary status; The monthly Maternity Dashboard evidences 100% compliance with targets of 1:1 care in labour. The department has sustained 100% compliance with this standard for >10 years<br>A Nursing Workforce Report is regularly submitted to the Board. | YES |

| **Safety action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two? | Met Y/N |
|---|---|
| **Required Standard:**<br>1. Trust Board level consideration of how the organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.<br>Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.<br>2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network<br>3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.<br>The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. | |
| **Trust's Commentary and Evidence**<br>At DCH the criteria for all elements of Saving Babies' Lives v2 (SBLv2) have been followed since being introduced in 2019 and all standards are currently met.<br>DCH supports all pregnant women to stop or reduce smoking, this is currently run as an opt out service. All women are screened at booking and at 36/40, with referral to smoking cessation services undertaken. CO monitoring is normally offered to all women and people but this was suspended due to COVID-19. It is now being reintroduced successfully – with some individual reticence from some staff.<br><br>Fetal movement is discussed at every appointment and the pathway for reduced fetal movement is followed for women with reduced episodes of fetal movement. Antenatal CTG's are used on all episodes of monitoring for RFM's.<br>We have a dedicated antenatal clinic and consultant for those women at risk of premature birth with access to trans-vaginal scans<br>We have a robust fetal monitoring guidance policy and use the fresh eyes approach for all women in labour. DCH has employed a fetal monitoring lead midwife and obstetrician to support teaching and offer clinical support and teaching within the working environment. Online teaching sessions (monthly) have been very well attended<br><br>All women have their fundal height measured at each antenatal appointment from 26 weeks gestation which can identify growth outside of normal range and where required women are referred to the Day Assessment Unit for review and ongoing management. For those women that have had early identification of SGA at booking, growth scans are booked in line with SBLv2. | YES |

| **Safety action 7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | Met Y/N |
|---|---|
| **Required Standard:**<br>Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | |
| **Trust's Commentary and Evidence**<br>• As an LMS we meet monthly with our MVP lead who contributes to the development of local maternity care.<br>• The MVP attends the Partnership meeting with the LMS, including the two heads of midwifery. She is also available on email and phone and regular discussion takes place regarding comms, service improvement and specific projects including improving services for Black, Asian and minority ethnic women, and all pandemic<br>• During our Partnership meetings we review service user feedback, complaints, plaudits, actions from the last Partnership meeting.<br>• During the pandemic we have had increasing contact with the MVP lead to assist with sharing important information about service changes receive service user<br>• Once restrictions are lifted, the MVP will visit the maternity unit to collect feedback from new mums and new parents which provides both qualitative and quantitative feedback. Currently feedback is generated via social media<br>• Our MVP lead reviews all protocols and leaflets as part of the ratification to review the language and terminology form a service users' perspective, their comments are valued and steer our work. She has made a very valuable contribution to the development and ongoing review of the Maternity Matters website | YES |

| **Safety action 8**: Can you evidence that the maternity unit staff groups have attended an 'in-house' multi- professional maternity emergencies training session since the launch of MIS year three in December 2019? | Met Y/N |
|---|---|
| **Required Standard:**<br>Can you confirm that:<br>a) Covid-19 specific e-learning training has been made available to the multi-professional team members?<br>b) teams required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?<br>c) there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted. | |
| **Trust's Commentary and Evidence**<br>Staff accessed online training about the use of PPE during the pandemic. Sim training relating directly to covid-29 was undertaken on the maternity unit<br>The maternity education team have reintroduced face-to-face training for PROMPT (Practical Obstetric multi professional training)<br>This would meet the requirement for CNST. Attendance is monitored by the Practice Development Lead midwife and reported into the LMS safety Meeting.<br>All content is based on current evidence, national guidelines and local systems and risk issues. Real incidents are incorporated into the simulations<br>The content can be locally produced or using the national available resources including video simulations, on-line presentations, national resources and/or interactive video-conferencing.<br>Our NLS update is delivered by trained NLS providers through scenario based teaching and discussion both in house and externally | YES |

| **Safety action 9**: Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues? | Met Y/N |
|---|---|
| **Required Standard:**<br>a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.<br>b) Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.<br>c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.<br>d) Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to:<br>I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes.<br>II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.<br>III. The MBRRACE-U SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf<br>IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I.<br>e)The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas:<br>• Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns<br>• Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with | |
| **Trust's Commentary and Evidence**<br>• Maternity safety champions at every level – trust, regional and national – work across regional, organisational and service boundaries to develop the strong partnerships needed to deliver better care. They play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.<br>• At DCH the Board level safety champion is the Chief Nurse Officer. She actively sponsors maternity items at the Trust Board. The Maternity Safety Champion is the lead midwife for Risk Management alongside a neonatal safety champion, anaesthetic safety champion and an obstetric safety champion. All four meet with CNO bi-monthly. The safety group operate independently from the head of midwifery to bring 'fresh-eyes' to any and all issues of concern.<br>• Display boards with the names and contact details of the safety champions visible in the maternity unit<br>• The pathway for escalating concerns to safety champions is embedded within the Risk Management Strategy with the NED profiled in the newsletter<br>• The Safety Team presented at MatNeoSIP events and have been actively involved since their inception.<br>• The CNO regularly visits the Maternity Unit and has held drop-in events – following on from one of these events, mobile phones were provided to lone community workers<br>• The service has been actively working with the Health Safety Investigation Branch (HSIB) since May 2018 and the head of midwifery and safety champions regularly meet with HSIB to discuss findings following the conclusion of investigations into several referred cases, and further engagement sessions are scheduled on a quarterly basis<br>• The Maternity Dashboard provides risk and safety performance measures and is available to all staff via email. The dashboard is being revised in line with current safety and quality indicators<br>• Performance against safety metrics are reviewed by the Trust Quality Committee which reports to the Executive Team. . | YES |

| **Safety action 10**: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? | Met Y/N |
|---|---|
| **Required Standard:**<br>a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.<br>b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.<br>c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that:<br>1. the family have received information on the role of HSIB and the EN scheme; and<br>2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. | |
| **Trust's Commentary and Evidence**<br>From 1 April 2017 it was required to report within 30 days all maternity incidents of potentially severe brain injury, namely all babies born at term (≥37 completed weeks of gestation), following labour, that had a potentially severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the categories:<br>• Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or<br>• Was therapeutically cooled (active cooling only) or<br>• Had decreased central tone AND was comatose AND had seizures of any kind<br>To date, eight cases have been referred to HSIB. Of these, three were rejected (two duplicates, 1 HSIB criteria not met), and five have progressed to an investigation. Five investigations completed and no outstanding cases currently. Parents were involved in all investigations and meetings offered with the Trust and HSIB investigators | YES |

**5. NEXT STEPS AND RECOMMENDATIONS**

5.1 Confirmation from the Board they accept DCH compliance with the ten maternity safety actions
5.2 Confirm who will act as signatory to the declaration on behalf of the Board
5.3 Ensure signature and submit the signed declaration form by mid-day 15 July 2021

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|---|---|
| **Meeting Title:** | Board of Directors Part One Meeting |
| **Date of Meeting:** | 28 July 2021 |
| **Document Title:** | **Annual Quality Account 2020/21** |
| **Responsible Director:** | Nicky Lucey, Chief Nursing Officer |
| **Author:** | Kerry Little, Quality Assurance manager |

| | |
|---|---|
| **Confidentiality:** | *No* |
| **Publishable under FOI?** | Yes |

| **Prior Discussion** | | |
|---|---|---|
| **Job Title or Meeting Title** | **Date** | **Recommendations/Comments** |
| Quality Committee | 22 June 2021 | Recommended to Board for approval |
| Board of Directors | 30 June 2021 | Approved outside the meeting for publication |
| Risk and Audit Committee | 20 July 2021 | Noted |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Purpose of the Paper** | For the Board to ratify the approval of the Quality Account. Quality Account was approved by Board via email on 30 June 2021 and was submitted to NHSEI and published on the Trust's website on that day. | | | | | | | |
| | *Note (✓)* | | *Discuss (✓)* | | *Recommend (✓)* | | *Approve (✓)* | *To ratify* |
| **Summary of Key Issues** | The Trust is mandated to produce an Annual Quality Report as a standalone part of the Annual Account. The Report must conform with the specific requirements set out by NHS Improvement'. As such, much of the information contained within is mandated; **specific language and terminology must be applied; sectioning, numbering and order of information is specified.** The source of the information contained within **is also specified** e.g. NHS Digital. Some of the information required is not nationally published until after the date of submission of the annual report; where this is applicable is noted within the report.<br><br>The production of the Quality Report for 2020/21 has been effected by the national Covid pandemic. The impact has been:<br><br>• It will not be as detailed as previous publications, as some data will be incomplete. Trust are encouraged to produce an 'abridged version' to be shared with the Clinical Commissioning Group as best practice. No new guidance for the Quality Report 2020/21 was published and therefore the contents are based on the previous year's guidance and in line with Reducing burden and releasing capacity to manage the COVID-19 pandemic.<br><br>• Statements of assurance: In light of the Covid pandemic, new guidance was published which stated that NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20. No new guidance was published for 2020/21<br><br>• NHS foundation trusts are also not required to include a Quality Report as part of their annual report for 2019/20<br><br>• There was no change to the legislation and the deadline date to publish | | | | | | | |

the Quality Report therefore remains 30th June 2021

- Dorset CCG – will receive the DRAFT report, a statement is being produced and will be inserted as best practice following any recommendations made by the Quality Committee.

- Clinical audits in the Quality Report are reduced due to cessation of audit activity nationally. Many of the national audits remained open on a voluntary basis, as they were keen to understand the impact of Covid-19, although publishing of reports was suspended. NCEPOD suspended all of their current studies during the pandemic. The responses from clinicians in relation to published reports have been affected as clinical priority took precedence over summarizing National reports. Some national audit data is also not available as a consequence.

- Local clinical audit was suspended in line with the above. In reality some areas found they had capacity to carry on as part of quality improvement, and several Covid-19 related audits were registered

Key abridged Quality Report headlines:
This report covers the period of April 2020 – March 2021. Quality achievements of particular success during this time period include:

| | |
|---|---|
| Improved Mortality Surveillance and Learning from Deaths:<br>Robust methodology for mortality has led to a consistent improvement in our SHMI data |  |
| Introducing three High Impact Interventions to Reduce Hospital Falls:<br>Reduction in falls resulting in severe harm |  |
| Improving the support from Hospital Volunteers:<br>Implementation of a Young Volunteer Programme, |  |
| Improving the health and wellbeing of staff:<br>Continuation of initiatives to support staff health and wellbeing |  |
| Improved learning from Complaints:<br>Learning Opportunities included in all responses to complaints |  |
| Improving the identification of Nutritional needs and support offered to patients through:<br>Quality Improvement Programme in Malnutrition Screening and care |  |

Quality Report Priorities for 2021-2022:
In line with national guidance normally priorities for the forthcoming year are created, following engagement with our clinical staff, our partners, our executive team, local community representatives and, of course, our patients and their families. No new priorities have been set due to the changes in National Guidance during the Pandemic. Therefore the historic priorities will stand during 2021/22 and refreshed ready for 2022/23.

Quality Committee work plan has refreshed focus areas for quality improvement, aligned to areas the committee and Board have considered key to support the

| | |
|---|---|
| | Trust strategy.<br><br>Quality Report Priorities carried forward include<br><br>**Patient Safety:**<br>• Introducing three High Impact Interventions to Reduce Hospital Falls<br>• Improved Mortality Surveillance and Learning from Deaths<br>• Improving early identification and treatment of Sepsis and the Deteriorating Patient<br><br>**Clinical Effectiveness:**<br>• Improving timely access to Mental Health services when needed<br>• Improving the health and wellbeing of staff<br>• Reducing unwarranted variation (Implementing best practice linked to clinical audits)<br><br>**Patient Experience:**<br>• Improved learning from Complaints<br>• Improving the identification of Nutritional needs and support offered to patients<br>• Improving the support from Hospital Volunteers |
| **Action recommended** | The Board is requested to ratify the Quality Account, which was previously approved by the Board outside the meeting for publication. |

**Governance and Compliance Obligations**

| | | |
|---|---|---|
| **Legal / Regulatory** | Y | Trust Boards must have oversight of the progress delivered against the Quality Account.<br>Inability to achieve the improvements could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience. |
| **Financial** | N | |
| **Impacts Strategic Objectives?** | Y | In previous years, NHS Foundation Trusts have been required to publish a Quality Account/Report each year in line with the NHS Act (2009) and quality account regulations (2010).<br>The Quality Report will not be published as part of the Annual Report this year due to new guidance covering the current pandemic. The Quality Report will be submitted and published in line with the recommended deadline of 30 June 2021 |
| **Risk?** | Y | External agencies that have previously been required to provide a statement are not required this year due to changes in requirement in response to Covid-19.<br>There remains National audit and performance data not yet available for inclusion within the report. |
| **Decision to be made?** | Y | Provide scrutiny of the report prior to publication. Recommend areas for improvements. Recommend submission to the Board as per the legislative timeframe |
| **Impacts CQC Standards?** | Y | As this report incorporates standards outlined by the CQC it is important to note progress or exceptions to these standards. |
| **Impacts Social** | N | |

| | | |
|---|---|---|
| **Value ambitions?** | | |
| **Equality Impact Assessment?** | N | |
| **Quality Impact Assessment?** | N | |

Respect
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NHS
Dorset County Hospital
NHS Foundation Trust

# Quality Account

2020 - 2021

**Outstanding care for people in ways which matter to them**

# Quality Report

## Quality Accounts and Approach to Quality

### What is a Quality Account?

Every NHS trust is required to produce an annual report and annual accounts. Within the annual report, there is a chapter which reports on our annual quality accounts, and these Quality Accounts are also published on NHS Choices.

NHS foundation trusts, such as Dorset County Hospital NHS Foundation Trust (DCHFT), have to submit these to Parliament and to our independent regulator, NHS Improvement. This happens in July each year and the reports are also published on our website.

The quality accounts are intended to allow people to compare the performance of different trusts as we are all required to report on predominantly the same things. They contain the quality priorities that we set for our hospital and services, and report back on our progress in achieving the priorities that we set ourselves the previous year.

As the Coronavirus Pandemic continues, and in line with National Guidance, the Quality Account for 2020/21 are again an abridged version and no new priorities have been set for 2021/22.

The following report does not reflect all of the improvement's that have been made at DCHFT, but does report on the nine Quality account priorities that were selected for inclusion in 2019/2020 Quality Account.

Dorset County Hospital NHS Foundation Trust (DCHFT) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2020/21. For complete quality and performance data the public can access Trust Board papers

This report covers the period of April 2020 – March 2021.

### Our Approach to Quality

As part of the standards for patient services detailed within the NHS Constitution and the Care Quality Commissions' ('CQC's') fundamental standards of quality and safety, the Trust is committed to the provision of safe, high quality care and achieving a good or outstanding CQC rating. An overall rating of 'Good' was achieved in 2018 and the Trust continues to aim to improve to 'Outstanding'.

Scheduled CQC Inspections are currently suspended due to the Covid-19 pandemic. A Transitional Regulatory Approach TRA has been implemented and services are engaged in monitoring discussions with local and regional inspection teams. The TRA provides CQC with a 'risk rating' for the service, however this does not result in a formal report, nor can it lead to a change in rating for the service or the provider. The Trust engages in Quarterly relationship meetings with CQC and continues to identify and implement improvements to services.

## Part 1: Statement on Quality from the Chief Executive

It gives me pleasure to introduce our Quality Account for Dorset County Hospital NHS Foundation Trust (DCHFT). I am delighted to share the progress and achievements our staff have made during 2020-2021 in conjunction with our patients and stakeholders. Despite the Covid-19 pandemic the Trust has maintained its focus on quality improvement and safety for our local and specialist population.

The account details the progress made against the priorities set for last year; it will also detail the decision to retain those priorities into the forthcoming year 2021-2022. This decision reflects the current and ongoing pandemic which has resulted in some areas of reporting being paused in order to free up essential resources within the Healthcare system (in line with the National Guidance).

I am pleased to confirm that the Board of Directors has reviewed the 2020-2021 Quality Account and are assured that it is an accurate and fair reflection of our performance.

On behalf of the Board, I wish to thank our staff for their dedication and resilience during this time and our partner organisations for their continued support.

Finally, I would like to thank our patients, their families and the local community for their invaluable and ongoing support.

**Patricia Miller, CEO**

To the best of my knowledge, the information within this document is accurate

…….Date …….....Chief Executive Officer

# Part 2: Priorities for improvement and statements of assurance from the board

## 2.1 Priorities for Improvement 2021-2022

Normally in line with national guidance we develop our priorities for the forthcoming year following engagement with our clinical staff, our partners, our executive team, local community representatives and, of course, our patients and their families. No new priorities have been set due to the changes in National Guidance during the Pandemic

Priorities for 2021/22 have not been set as acute providers were asked to concentrate resources to the pandemic effort.

All government recommendations will be followed and the Trust will be looking at its priorities for the coming year.

Priorities carried forward

**Patient Safety:**

- Introducing three High Impact Interventions to Reduce Hospital Falls
- Improved Mortality Surveillance and Learning from Deaths
- Improving early identification and treatment of Sepsis and the Deteriorating Patient

**Clinical Effectiveness:**

- Improving timely access to Mental Health services when needed
- Improving the health and wellbeing of staff
- Reducing unwarranted variation (Implementing best practice linked to clinical audits)

**Patient Experience:**

- Improved learning from Complaints
- Improving the identification of Nutritional needs and support offered to patients
- Improving the support from Hospital Volunteers

Progress against these quality account priorities will continue to be monitored and reported through the Trust sub-board Quality Committee. They will also be regularly reported to the Dorset Health Overview Scrutiny Committee and will be reported to the local commissioners.

**Quality Achievements 2020/2021**

Below are listed some of quality improvement projects of particular success in 2020/2021:

| | |
|---|---|
| Improved Mortality Surveillance and Learning from Deaths:<br><br>Robust methodology for mortality has led to a consistent improvement in our SHMI data | ✓ |
| Introducing three High Impact Interventions to Reduce Hospital Falls:<br><br>Reduction in falls resulting in severe harm | ✓ |
| Improving the support from Hospital Volunteers:<br><br>Implementation of a Young Volunteer Programme, | ✓ |
| Improving the health and wellbeing of staff:<br><br>Continuation of initiatives to support staff health and wellbeing | ✓ |
| Improved learning from Complaints:<br><br>Learning Opportunities included in all responses to complaints | ✓ |
| Improving the identification of Nutritional needs and support offered to patients through:<br><br>Quality Improvement Programme in Malnutrition Screening and care | ✓ |

## 2.2 Statement of Assurance from the Board

1. During 2020-2021, the Dorset County Hospital NHS Foundation Trust (DCHFT) provided and/or subcontracted 35 relevant health services.

1.1 The Trust has reviewed the data available to them on the quality of care in all of these relevant services in line with the national pandemic.

1.2. The income generated by the relevant health services reviewed in 2020-2021 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2020 – 2021.

2. During 2020-21 44 clinical audits covered relevant health services that the Trust provides.

2.1 During that period the Trust participated in 94% National Clinical Audits which it was eligible to participate in and 100% National Confidential Enquiries which it was eligible to participate in.

2.2 The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2020-21 are as follows within the table.

2.3 The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2020- 2021 are as follows within the table:

2.4 The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2020-21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

## National Clinical Audits

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such we are required to participate in those that relate to services provided by this Trust. The following table describes the audits we have participated in, and the relevant compliance.

**Covid-19 and Clinical Audit**

With the advent of Covid-19, NHS England/Improvement took steps to reduce burden, and release capacity within the NHS care settings. The impact of this on clinical audit was an immediate cessation of all audit activity, with exception of a few specific projects, to allow clinical teams to focus on the unfolding situation. In reality, many of the national audits remained open, and clinical teams continued to submit data as they were keen to understand the impact of Covid-19 on their specific services, although publishing of reports was suspended.

Local audit was suspended in line with the above, although some areas found they had capacity to carry on, and several Covid-19 related audits were registered, still ongoing at this time.

* Please note that in some cases the % of Registered Cases is above 100%; this is because the trust was able to identify additional cases than those identified by the HES (Hospital Episode Statistics) data

| Name of Audit | Trust Eligible | Trust Participation | Cases Submitted | % of Registered Cases |
|---|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Y | Y | 133 | |
| Cardiac Rhythm Management (CRM) | Y | Y | 435 Submitted 309 HESS data | 141% |
| National Heart Failure Audit | Y | Y | 340 Submitted 664 HES data | 51% |
| Coronary Angioplasty/National | Y | Y | 388 Submitted 274 HES data | 142% |

| | | | | |
|---|---|---|---|---|
| Audit of Percutaneous Coronary Interventions (PCI) | | | | |
| **Name of Audit** | **Trust Eligible** | **Trust Participation** | **Cases Submitted** | **% of Registered Cases** |
| National Audit of Cardiac Rehabilitation | Y | Y | Figures pending | |
| Diabetes (Paediatric) | Y | Y | 110 | 100% |
| National Diabetes Audit – Adults | Y | Y | Figures pending | |
| National Diabetes Foot Care Audit | Y | Y | 100 | 100% |
| National Diabetes in Pregnancy Audit | Y | Y | 14 | 100% |
| National Audit of Care at the End of Life | Y | N | Did not run 2020-21 postponed due to Covid-19 | |
| National Audit of Dementia | Y | N | Did not run 2020-21 postponed due to Covid-19 | |
| National Asthma and COPD Audit Program | Asthma | Y | 14 Submitted | HES data not used |
| | COPD | Y | 72 Submitted | |
| | Children and Young Peoples Asthma | Y | 3 Submitted | |
| National Lung Cancer Audit | Y | Y | 131 | |
| Sentinel Stroke National Audit Programme (SSNAP) | Y | Y | 389 | |
| Major Trauma Audit (TARN) | Y | Y | 287 Submitted | 100% |
| PHE Surgical Site Surveillance Audits | Y | Y | # NOF - 53 Submitted<br>Breast – 65 Submitted | |
| National Audit of Breast Cancer in Older Patients | Y | Y | 194 | |
| Inflammatory Bowel Disease (IBD) Registry Biologics Programme | Y | Y | 1170 | 100% |
| National Gastro-Intestinal Cancer Programme | Oesophago-gastric Cancer (NAOGC) | Y | Figures Pending | |
| | Bowel Cancer (NBOCAP) | Y | Figured Pending | |

| Name of Audit | Trust Eligible | Trust Participation | Cases Submitted | % of Registered Cases |
|---|---|---|---|---|
| National Emergency Laparotomy Audit | Y | Y | 98 Submitted | Data incomplete due to Covid-19 impact |
| National Joint Registry | Knees primary/Revision | Y | 35 | Significant impact on elective surgery due to Covid-19 |
| | Hips primary/revision | Y | 48 | |
| Falls and Fragility Fractures Audit programme (FFFAP) | Fracture Liaison Service | Y | 1230 | |
| | Inpatient Falls | Y | 2 | 100% |
| | Hip Fracture Database | Y | #NOF 332 Submitted Other 49 Submitted | 100% |
| National Prostate Cancer Audit | Y | Y | Network submission via UHD-NHS | |
| National Audit of Rheumatoid and Early Inflammatory Arthritis | Y | Y | 76 | |
| Endocrine and Thyroid National Audit (UK Registry) | Y | Y | Figures pending | |
| Case Mix Programme ICNARC | Y | Y | 874 | 100% |
| Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE) | Y | Y | 10 | 100% |
| National Maternity and Perinatal Audit (NMPA) | Y | Y | 39 | 100% |
| Child Health Clinical Outcome Review Programme | Y | Y | Figures pending | |
| Neonatal Intensive and Special Care (NNAP) | Y | Y | 220 | 100% |
| National Audit of Seizures and Epilepsies in Children and Young People | Y | Y | 85 | 100% |
| National Cardiac Arrest | Y | Y | 39 | 100% |

| | | | | |
|---|---|---|---|---|
| Audit (NCAA) | | | | |
| **Name of Audit** | **Trust Eligible** | **Trust Participation** | **Cases Submitted** | **% of Registered Cases** |
| National Ophthalmology Audit | Y | N | Did not participate | 0% |
| Learning Disability Mortality Review Programme (LeDeR) | Y | Y | 2 | 100% |
| Perioperative Quality Improvement Programme (PQIP) | Y | Y | Ongoing QI project | |
| Serious Hazards of Transfusion: UK National haemovigilance scheme. Scheme (SHOT) | Y | Y | 4 | 100% |
| Society for Acute Medicine's Benchmarking Audit (SAMBA) (49) | Y | N | Did not run 2020-21 postponed due to Covid-19 | |
| Antenatal and new-born national audit protocol 2019 to 2022 | | | | |
| Emergency Medicine QIPs [3] | Fractured Neck of Femur | Y | 59/50 | 118% |
| | Infection Control | Y | 27/50 | 54% |
| | Pain in Children | Y | Data collection closes October 2021 | |
| NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections. | Y | N | Did not run 2020-21 postponed due to Covid-19 | |
| UK Renal Registry National Acute Kidney Injury programme | Y | Y | Figures pending | |

**National Confidential Enquiries into Patient Outcome and Death (NCEPOD)**

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research.

At the beginning of the Covid-19 pandemic, NCEPOD also suspended all of their current studies to allow clinical resource to be focused on the emerging situation.

| Name of Audit | Trust Eligible | Trust Participation | Cases Submitted | % of Registered Cases |
|---|---|---|---|---|
| Out of Hospital Cardiac Arrest | Y | Y | 0 | 100% |

The following shows the National reports published and a precis of their findings:

| Report Title | Report Precis |
|---|---|
| **NCEPOD Time Matters: Out of Hospital Cardiac Arrests** | Organisational survey completed and returned, but no cases selected for review. Report published February 2021. Summary pending, delayed due to Covid-19 |

2.5 The reports of 5 National Clinical Audits were reviewed by the provider in 2020-21, the number lower than expected as Covid-19 impacted on report publication.

2.6 The table below summarises the audit outcomes and the actions taken as identified by the review undertaken:

| Audit / Clinical Outcome Review Programme | What this Trust learnt |
|---|---|
| **National Cardiac Arrest Audit (NCAA) 2019** | The hospital performance comparator shows that DCH survival rate matches the national average.<br>The Trust been able to compare the local hospital CA survival rate for 3 month periods both pre and during COVID.<br>There was no decrease in survival to discharge. Total arrests per year are approx. 50 i.e. about 1 per week).<br>No evidence of delay to treatment where full Personal Protective Equipment (PPE) is required to be worn during adult cardiac arrest. |
| **NDA National Diabetes Audit 2019** | Decline in 8 care processes mainly due to lower urine albumin checks (BMI improved)<br>Most care processes remain well completed but lower for type 1 patients (10-70% vs 20-80%)<br>15% of Type 1 (T1) and 5% of Type 2 (T2) patients did not have a |

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| | HbA1c (glycated haemoglobin) check during the audit period<br>Achievement of treatment targets have improved in T1 pts driven by improved HbA1c</=58 but not in T2 pts.<br>Some services achieving HbA1c>40%, BP>80%, statins >80% T1s and HbA1c >70%, BP >80% and statins >90% for T2s<br>f. Lower rates of statin prescription for primary prevention in T1 vs T2 (with some services achieving >75%)<br>g. More than 25% T2s not prescribed statins for primary prevention (some services achieving >85%)<br>h. Some areas achieve >30% T1 and >45% T2 pts<br>i. Structured Education offer and attendance remains stable but attendance recording remains poor.<br>Actions:<br>Improve quality of NDA data in order to benchmark the trust against national results |
| **National Asthma and COPD audit programme (2018-19 data) Report published July 2020** | Areas of good performance:<br>Length of stay for acute exacerbation of chronic obstructive pulmonary disease (**AECOPD**) (3 days) (average)<br>% of COPD patients with oxygen prescribed (78%)(above average)<br>% of COPD patients needing NIV receiving it within 2 hours of arrival (26%) (above average)<br>Areas of concern:<br>Spirometry result not available (23%) – Action: hospital lung function results are now available on ICE.<br>Referral to stop smoking service (39%) – Action: Part of the COPD discharge bundle<br>Patient received a respiratory review within 24 hours of admission (64%) – Action: identifying all COPD and asthma admissions on Careflow each weekday for review by a respiratory consultant.<br>Discharge bundle completion (32%) – Action: Identification of additional resource required for completion. |
| **National Cardiac Audit Programme (NCAP) Cardiac rehabilitation (January-December 2019 data) Report published October 2020** | Our CR programme was assessed as part of the 2020 BACPR/NACR NCP_CR (The National Certification Programme for Cardiac Rehabilitation) as meeting sufficient standards to be classified as Amber.<br>Our programme met 6 out of the 7 required Key Performance Indicators (KPIs):<br>• Multidisciplinary team: KPI Met<br>• Priority Groups: KPI Met<br>• Duration (days): KPI Met<br>• Percentage with Assessment 1: KPI Met<br>• Wait time Coronary Artery Bypass Graft (CABG) : KPI Met<br>• Wait time Myocardial Infarct/Percutaneous Coronary Intervention : KPI Met<br>In 2019, cardiac rehabilitation team in Dorset County Hospital met 6 of the 7 National Key Performance Indicators, (KPI's).<br>In 2019, 91.3% of patients who were appropriately referred to cardiac rehabilitation completed their Core Cardiac Rehabilitation Program which is significantly above the national average.<br>Patients were offered a range of cardiac rehabilitation options including the Cardiac Event Follow-Up Clinic, Phase III exercise and health education groups, the My heart online platform, the Heart Manual book and CD's, the My Personal Trainer exercise DVD's and book, British |

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|---|---|
| | Heart Foundation and other local organisation literature and telephone follow-up reviews.<br>By the end of 2019, nationally, only 26% of cardiac rehabilitation teams offered technology/online cardiac rehabilitation options. We helped develop the My heart app.<br>In 2020<br>Cardiac rehabilitation face to face clinics and groups had to be suspended in March 2020 due to the COVID 19 pandemic and this had significant impact on service provision.<br>Face to face clinics for cardiac surgery patients were re-commenced in July 2020 due to clinical need. Non-surgical patients continue to be offered their clinical assessment by telephone consultation only.<br>All written, DVD and online and telephone options of cardiac rehabilitation are continuing throughout 2020.<br>Assessment 2 targets were not fully met in 2019 and due to the COVID19 pandemic the Assessment 2 target will again not be met for 2020. |

## Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services for improving. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 177 local audits were registered during 2020-21 and work will continue to see these through to completion.

2.7 The reports of 72 local clinical audits were reviewed by the provider in 2020-21. This is lower than in previous years which may be attributed to the focus of resource on the Covid-19 pandemic

2.8 A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

| Name of Audit | Finding | Learning points |
|---|---|---|
| 5095 – Unplanned admissions after day care | This is an annual retrospective, internal, qualitative analysis audit to improve the quality of care of list planning; identification of high-risk patients during pre-assessment and the management of perioperative complications such as pain, nausea, and vomiting. The sample was all day case patients and the information collected from notes. | Learning points identified were effective communication between teams is crucial and following protocols and bundles help uniformity of care and reduces near misses and harm. Therefore, it is recommended that: Identification of high-risk patients during pre-assessment - ECG for over 60 reviewed and documented; Post spinal care - Updated existing documentation and education for the theatre team done in the form of group interactive sessions |
| 5024 - Compliance audit for following the NICE guidance on Routine Pre-operative Testing for Elective Surgery (1556-1 Routine Pre-operative Tests for Elective Surgery) | The aim of this retrospective audit looked at a cross section of 80 patients aged 65 plus presenting for major or complex surgery deemed fit following a Nurse led clinic pre-operative assessment between 7th August 2019 and 2nd February 2021. | All 80 patients sampled and reviewed were found to have the correct tests pre-operatively in line with national guidance NG54 guideline since 2016 and have produced clear, colour-laminated guides which are on show throughout the PAU area. When the guideline was first created in 2016, educational sessions to reinforce the standards and a Trust guideline was formalised and made available for ease of use. We are pleased to show we are compliant and that our practice is consistent with national standards |
| 5202 – Audit of Balloon Gastrostomy | This internal clinical audit aims to identify compliance with the LocSSIP Safety Checklist for BGT Procedures, any | The audit revealed that an Electronic Discharge Summary (EDS) is not always completed |

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|---|---|---|
| Tubes (BGT) – Local Safety Standards for Invasive Procedures (LocSSIP) | amendments to be made to the LocSSIP Safety Checklist Procedures and to address any non-compliance through training and reflective practice for all staff involved. The sample involved 6 patients attending hospital for BGT change. | however an email would be sent to the Home Enteral Nutrition Team and Nutricia Nurses for each patient and recorded on System One. Given that the NPSA recognised that the patient remains at risk for 72 hours post procedure it is essential to also create an EDS so GP and out of hours teams could access this information. |
| 5029 – Unlicensed Medicines Audit | The aim of this annual audit is to ensure unlicensed medicines are procured prescribed and dispensed safely and in accordance with Trust Policy; and to ensure that the systems are appropriately established, maintained and to reduce the risk posed to patients, prescribers and pharmacists by unlicensed medicines.<br>The key findings of audit compliance showed that at the start of the audit (01/04/19) 94 products were in use and 69 products were out of use during the audit period– 75% of risk assessments were completed with 74.5% of prescriber authorisation forms completed; therefore overall compliance upon commencement was 50%.<br>At the end of the audit (31/03/20) 83 products were in use and 80 were out of use. 100% of risk assessments were completed and 95.2% of prescriber authorisation forms were completed. | Regular recurring reviews of the unlicensed medicines database is required and a system in place for updating SharePoint each time a new unlicensed medicine is added to JAC. By adding this recurring check into the Key Performing Indicators (KPIs) reporting that takes place at the start of every month, discrepancies and non-compliance will be highlighted and actioned in a timely manner to reduce any risks bought about from the supply and use of unlicensed medicines within DCHFT. |
| 4981 – Audit of the current management of acute abscess presentation at Dorset County Hospital (DCH) | The aim was to establish current clinical practice for the management of acute abscesses, including breast abscess; to evaluate the use of Day Case CEPOD surgery and to improve the current abscess pathway to reduce, where possible the length of patient stay and delays for surgical intervention. | The findings of the audit showed that most patients undergoing abscess drainage are fit and well, with no significant co-morbidities or signs of sepsis on presentation. That there is a considerable proportion of patients who are undergoing Out of Hours intervention for Incision and Drainage of the abscess; and there is a relatively high utilisation of surgical inpatients beds allocated to patients that are clinically well. |
| 5028 – Review of Orthoptic Stroke Patients | This was a retrospective review of Orthoptic referrals received between August 2019 and February 2020, via case notes/DPR review. The aim was to review the number of referrals that are received, now that the service is established. It looked at the number of referrals received, | As the number of patients being referred has increased, this shows that there is a demand for the service. The referrals will continue to be monitored to ensure patients are seen appropriately and in a timely |

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| | where they were seen, how long they had to wait for review and what they were referred in with. Previous data was used for comparison.<br>The number of referrals had increased from 27 to 57 in a 6-month period. A larger percentage of appointments were seen in the Outpatients Department (OPD) and 19% via phone consultation, the latter coinciding with lockdown.<br>Patients were seen quicker on the /stroke Unit, than OPD or telephone consultation.<br>Visual field defects are still the largest number of referrals with Ocular motility defects coming second. | manner.<br>Stroke patients will continue to be monitored and assessed on what impact the change of location of the Stroke Rehabilitation Unit is having on appointments and length of time to be seen. If the latter increases, it will be reviewed for the need of additional clinics. |
| 4924 - Continuous prospective audit of post-operative cataract surgery endophthalmitis rate for the Royal Eye Infirmary, Dorset County Hospital 2018-2020 | This is a prospective data collection from consecutive cataract cases performed at Dorset County Hospital (DCH). The aims were the collection of Endophthalmitis cases post cataract surgery; compare DCH rates of infection against published data and an in-depth analysis of any cases of Endophthalmitis to ensure best practice and the best possible outcome achieved.<br>The findings showed two cases of post-operative endophthalmitis post cataract surgery occurred during the audit period with 1,955 cataract procedures performed. The overall endophthalmitis rate for the rolling prospective audit period commenced in 2013 is 2 per 9,098 or 1 per 4,549 or 0.02%. | This audit was presented and discussed at the REI Clinical Governance meeting in January 2021.<br>It is recommended to continue to audit any cases of Endophthalmitis post cataract surgery; to maintain the current practice of no routine use of antibiotics in the cataract infusion bag; and an analysis of management of Endophthalmitis cases in event of an occurrence. |
| 4937 – Deteriorating Patient Pathway | The aim of this retrospective adult inpatient audit is to assess current practice in response to deteriorating patients to provide information for the development of all causes on the deteriorating patient pathway. The key findings showed a compliance of 22% for immediate escalation for medical review; 64% compliance of an appropriate increase in the frequency of observations; a medical review by the Critical Care and Outreach Team (CCOT) or Doctor (FY2 or above) within 1 hour with 6% compliance; 8% compliance of a repeat review within 6 hours and 3% compliance of consideration of TEP and/or DNAR. | The learning represented a small indicative sample with incomplete data due to poor documentation. There is a need for improvement on compliance with increasing observations frequency and lack of escalation and documentation of escalation. The majority were escalated to CCOT. There was a highly variable grade of initial review and timings to view because of poor escalation in a timely manner. Repeat reviews are rare and grade of initial view was highly variable. There was very poor consideration of Treatment Escalation Plan / do not attempt resuscitation TEP/DNAR in sick patients – this will be addressed through introduction of the all- |

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| | | cause deterioration form. |
| 5092 - Intra Venous (IV) line flush audit in Interventional Radiology 2020 | This is a retrospective service audit of the scanning of IV-line flush documentation. There were 25 cases reviewed and all cases were performed with a World Health Organisation (WHO) checklist and all IV lines flush was documented on all. | No learning points or recommendations were made. |
| 4992 - Child Sexual Exploitation (CSE) identification in Maternity Services at Dorset County Hospital Foundation Trust (DCHFT). | The aim of this audit is to ensure that CSE identification in DCHFT Maternity Services is meeting the required standard of compliance and accountability. Information regarding teenagers at risk of CSE was selected from excel spreadsheets that are populated by the Teen Midwives team, who record all pregnant teenagers booked for DCHFT. Data was then collected from the Digital Patient Records, CD View or CIVICA and the safeguarding files (for current pregnancies) in order to ensure that standards are being maintained. | Confirmation that midwives are continuing to take appropriate measures to ensure safety and support for children at risk of sexual exploitation. Practice will continue to remind midwives to ensure that all documentation is correctly completed at booking or revisited at the soonest opportunity to complete. |
| 5003 – Surgery for Endometrial Cancer | The aim of this retrospective audit is to see the proportion of hysterectomies for endometrial cancer that have had a Total Laparoscopic Hysterectomy (TLH), and the demographic of patients that we operate on. The sample was patients diagnosed with endometrial cancer between April 2019 and April 2020. 35 patients were identified, 16 were operated on elsewhere, 1 patient didn't have surgery, and 1 set of notes were unavailable. This left 17 patients who underwent surgery. The key findings showed that 94.1% of patients had a TLH (16/17) with one that was converted to laparotomy (due to a query regarding bowel perforation – there was no injury confirmed). This is clearly in keeping with the British Gynaecological Cancer Society (BGCS) guidelines; Mean blood loss was 138mls and the mean age 69.5; 60% of patients had mild systemic disease, 40% had severe systemic disease with 35% having class 1 obesity and the mean hospital stay was 1.8 days. Overall, the postoperative stay for TLH is comparable to studies where patients are undergoing TLH stay for approximately 2 days: half the time of patients undergoing open surgery. | TLH is a safe mode of surgery and should be used in preference to Total Abdominal Hysterectomy, apart from if the patient has had extensive surgery that may make laparoscopy unsafe. The audit confirms that TLH is a safe surgical approach for patients with endometrial cancer, despite having high BMIs. It also reduces hospital stay. Continue current management. |
| 4927 – DNAR Audit | This audit based on 12 wards and 75 sets of notes aims to assess and evaluate Do Not Attempt Resuscitation (DNAR) | It is recommended to continue DNAR training as part of mandatory/BLS/ILS updates; |

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| | documentation and completion within all relevant wards/areas in DCHFT (excluding the Emergency Department, Outpatients, Clinics, Theatres, Day Units and Paediatrics).<br>It was found 93.5% of forms were located at the front of the patient's notes; 87% of DNAR decisions had been clearly documented in the patient's notes either written or with the yellow sticker; 90% of decisions were made by the appropriate grade/trained clinician, 90% of decisions were ratified in 48hrs and 75% of TEP forms were present with DNAR in place. | reinforce the need for a TEP to be completed with a DNAR decision. |

3. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2020-2021 that were recruited during that period to participate in research approved by a research ethics committee was 797. We did not have an active recruitment target for this period due to the pandemic.

This is our lowest level of involvement in the last few financial years and reflects a sustained drop due to continued cuts in NIHR funding and available resource. We are looking to grow in collaboration with other care sites and have had our income sustained rather than cut moving into 2021, which we hope will be reflected by a year of recovery, resilience and growth.

It is worth noting that this period has seen success in the set up and delivery of UPH Covid-19 studies, with 30% of our covid-19 admissions recruited to the RECOVERY trial, substantially higher than the 10.9% average across Wessex.

4. The Trust income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework This was because of the changes in contracting arrangements due to COVID, as a result, defined CQUIN income was not received.

5. The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008.

5.1 The Trusts current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2020- 2021.

(Section 6 was removed from the legislation by the 2011 amendments)

7. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

7.1 CQC suspended scheduled onsite inspections during the Covid-19 pandemic. A Transitional Regulatory Approach was implemented and discussions took place with Maternity Services and Outpatient Services following this approach. In all cases there were no risks identified and no further action was required by DCHFT. There is no formal response or report resulting from this Transitional approach.

The Trust is currently rated 'Good' overall by the CQC following inspection in July – September 2018. The Trust continues to engage in quarterly meetings with the local and regional CQC inspection team.

The ratings grid below, as published by the CQC on its website, shows the ratings given to the core services and five domains at the time of their inspection (please note some areas were not re-inspected in 2018 following the 2016 inspection, therefore the 2016 rating stands for those services until the CQC re-inspect and rate accordingly):

**Ratings for Dorset County Hospital**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement → ← Oct 2018 | Good → ← Oct 2018 | Good → ← Oct 2018 | Good → ← Oct 2018 | Good ↑ Oct 2018 | Good ↑ Oct 2018 |
| Medical care (including older people's care) | Requires improvement Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Surgery | Requires improvement Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Critical care | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Requires improvement Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| Maternity | Requires improvement Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 |
| Services for children and young people | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 | Good Aug 2016 |
| End of life care | Good ↑ Oct 2018 | Requires improvement → ← Oct 2018 | Good → ← Oct 2018 | Good → ← Oct 2018 | Good ↑↑ Oct 2018 | Good ↑ Oct 2018 |
| Outpatients | Good Oct 2018 | N/A | Good Oct 2018 | Good Oct 2018 | Requires improvement Oct 2018 | Good Oct 2018 |
| Diagnostic imaging | Good Oct 2018 | Good Oct 2018 | Good Oct 2018 | Requires improvement Oct 2018 | Good Oct 2018 | Good Oct 2018 |
| **Overall*** | Requires improvement → ← Oct 2018 | Good ↑ Oct 2018 | Good → ← Oct 2018 | Good → ← Oct 2018 | Good ↑ Oct 2018 | Good → ← Oct 2018 |

8. The Trust submitted records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

| | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | National Average |
|---|---|---|---|---|---|---|
| **Admitted Patient Care** | 99.9% | 99.9% | 99.9% | 99.9% | 100% | 99.5% |
| **Outpatient Care** | 100% | 100% | 100% | 100% | 100% | 99.7% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Accident and Emergency Care** | 99.2% | 99.1% | 99.0% | 99.2% | 99.7% | 98.0% |

The percentage of records which included the General Medical Practice Code was:

| | 2016/17 | 2017/18 | 2018/19 | 2019/20 | | National Average |
|---|---|---|---|---|---|---|
| **Admitted Patient Care** | 99.9% | 100% | 100% | 100% | 100% | 99.8% |
| **Outpatient Care** | 100% | 100% | 100% | 100% | 100% | 99.7% |
| **Accident and Emergency Care** | 99.7% | 100% | 99.8% | 100% | 100% | 98.8% |

9. As at the end of April 2021, the Trust was compliant with 18 of the 42 assertions within the Data Security and Protection Toolkit (DSPT) and 3 of the 10 national standards. The internal audit performed by BDO LLP in February 2021 confirmed that the evidence provided for 35 of the 40 mandatory sub-assertion included in the sample were found to be satisfactory and in line with the requirements of the Independent Assessment Framework.

The Trust appointed an Information Governance Manager and Data Protection Officer who started in the Trust on 01 November 2020.

The Trust continues to gather the evidence needed to support the 2020/21 Data Security and Protection Toolkit, which, because of the pandemic, is now due for delayed submission on 30 June 2021.

10. The Trust was not subject to the Payment by Results clinical coding audit during 2020 – 2021.

11. The Trust will be taking the following actions to improve data quality:

- The Trust has improved capacity in its Clinical Coding Team and will be instigating a rolling monthly internal audit programme for 2021/22. This will be in addition to the mandatory Clinical Coding Audit as required by the Data Security and Protection Toolkit.via our PAS system and the Data Warehouse to highlight and address areas of concern.
- The Information Assurance Manager will be working with the Business Intelligence Team to validate the data within the suite of reports they produce in order to provide improved assurance to the end users.

- Data quality metrics and reports are used to assess and improve data quality. The Data Quality Maturity Index (DQMI) and the Secondary Uses Service (SUS) Data Quality Dashboards are monitored and reports run on a daily/weekly/monthly basis via our PAS system and the Data Warehouse to highlight and address areas of concern.

## 27 Learning from Deaths

The Trust has a full complement of Medical Examiners who perform brief reviews of every in-patient death and identify those cases that require further in depth reviews, using the Learning from Deaths national guidance. ('*National Guidance on Learning from Deaths*', National Quality Board, March 2017).

27.1 During April 2020 – March 2021 713 of DCHFT patients died. This compromised the following number of deaths which occurred in each Quarter of that reporting period:

- 153 First Quarter
- 153 Second Quarter
- 168 Third Quarter
- 239 Fourth Quarter

27.2 By 05/05/2021 189 case record reviews and 2 investigations have been carried out in relation to 713 of the deaths included in item 27.1.
In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 35 First Quarter
- 52 Second Quarter
- 63 Third Quarter
- 39 Fourth Quarter

27.3 2 representing 0.28% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 of 153 representing 0% for the first Quarter
- 1 of 153 representing 0.65% for the second Quarter
- 0 of 168 representing 0% for the third Quarter
- 1 of 239 representing 0.42% for the fourth Quarter

These numbers are derived from the judgement score for whether it is felt that the death was 'more likely than not' to have resulted from a problem in healthcare. All such cases are referred to, and reviewed by, the Hospital Mortality Group (HMG).

The HMG publishes a summary of outcomes from all reviews via its quarterly report to the Trust's public Board papers which are available via the Trust's internet site. Reports are shared internally by email newsletters. Any common themes identified feed into the quality improvement plans in the Trust, as part of the overall trust objective to deliver outstanding services every day. The notes of any patient who suffers a cardiac arrest are automatically subject to an SJR to examine whether it might have been preventable, regardless of the final outcome.

Specific areas of learning:

- Decisions on a patient's resuscitation status and appropriateness of escalation of care are occasionally but not uncommonly left to the out of hours Medical SPR, when they should have been dealt with in daytime

hours by the medical or surgical team who know the patient and their relatives best.
- 10 patient complaints were received relating to poor communication or completion of 'No Not Attempt Resuscitation' orders. Although this is a tiny proportion of all DNAR orders they proved very distressing for the individuals concerned.
- Abdominal pain with raised inflammatory markers should have a low threshold for early surgical consultation, especially where deterioration of the patient's physiology is apparent.
- Written note entries in the case record do not always have accurate times recorded and/or the staff member has not recorded their PIN number.
- Patients who are critically unwell with sepsis and or hypotension should not have non-steroidal anti-inflammatory drugs continued or initiated, and all antihypertensive medications should be reviewed for discontinuation.
- Surgical admission clerking and documentation is often too limited in its breadth, with incomplete construction of the differential diagnosis.
- VTE assessments are not recorded consistently.

27.5 A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the e provider has learnt during the reporting period.

Identified issues are communicated across the Trust via a newsletter, and cases of suboptimal care are forwarded to departmental Morbidity & Mortality meetings and Divisional, Care Groups and Specialty Governance meetings for further discussion and learning.

- An audit of DNAR forms was completed which identified that the large majority of forms are correctly completed, but that additional training would be beneficial on aspects of communication and documentation which have been problematic during the COVID 19 pandemic. A training plan is currently being discussed and an action plan will be put in place.
- The patient record note paper has been redesigned with various printed watermark reminders for all staff to remind them to date, time, sign and record their PIN number with each entry. Previously there were no visual cues to remind staff.
- Identification of a deteriorating patient, especially where sepsis or cardiac arrest occurs remains a priority. An 'All Cause Deterioration' pathway is being introduced across the Trust, aligned to quality and safety improvement work in the Trust. These forms should improve the early and appropriate escalation of a deteriorating patient and will be audited once embedded. The form was developed by the Regional Deteriorating Patient network overseen by the Wessex Academic Health Science Network (AHSN) and then localised to DCH.
- Differential diagnosis is to be included in the teaching rota of all F1 doctors.
- VTE assessment recording was modified, tested on 4 ward areas and introduced Trust-wide in July 2020.

27.6 An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

- Timing & Signing of notes entries – the redesigned note paper began to arrive in the Trust during Q4 2020/21, and its effect will be audited during 2021/22.

- Identification of a deteriorating patient is under constant review by the Trust's sepsis group, and the 'All Cause Deterioration' documentation is coming into use from 2020/21 Q4.
- All case notes involving the End of Life Care pathway are reviewed by the EoLC group, chaired by a palliative care consultant, and with a review of DNAR orders and appropriateness of escalation of care decisions. Results are to be reported back to HMG on a regular basis.
- Surgical admission clerking/differential diagnosis is now a taught session as part of FY1 education – usually delivered by the Trust Medical Director. Notes will be reaudited during 2021/22.
- VTE assessments have exceeded the national standard of 95% within 24 hours of admission for every month since the change to the reporting process was introduced. The Trust's Thromboembolism Group has been reconfigured with a dedicated consultant lead from May 2021.

27.7 22 case record reviews and 4 investigations completed after 31/03/2020 which related to deaths which took place before the start of the reporting period.

27.8 2 representing 22 (9.09%) of the patient deaths before the reporting period, are judged to have been due to problems in the care provided to the patient. This number has been estimated using the judgement score for whether death is determined more likely than not to have resulted from a problem in healthcare.

27.9 6 representing (0.75 %) of the patient deaths during 01/04/2019 to 31/03/2020 are judged to be more than not to have been due to problems in the care provided to the patient.

## Reporting Against Core Indicators

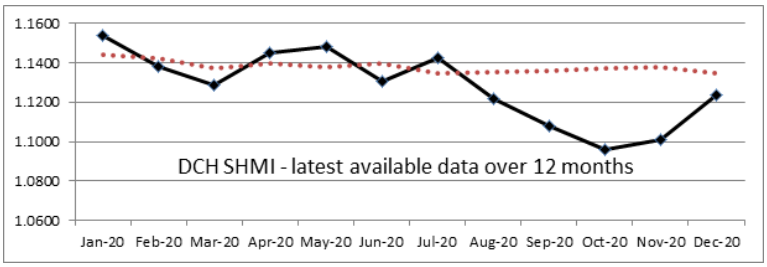
### Mandatory Statement 12: Mortality

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It covers all deaths of patients who were admitted to non-specialist acute trusts in England, and who either died in hospital or within 30 days of discharge.

A lower score indicates better performance. In addition to individual scores, trusts are categorised into one of three bandings: 1 (SHMI higher than expected); 2 (SHMI as expected); 3 (SHMI lower than expected).

| | Jan 2020 | Feb 2020 | Mar 2020 | Apr 2020 | May 2020 | Jun 2020 | Jul 2020 | Aug 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Dec 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DCH SHMI 2020 | 1.154 | 1.138 | 1.129 | 1.145 | 1.148 | 1.130 | 1.142 | 1.122 | 1.108 | 1.096 | 1.101 | 1.124 |
| DCH SHMI Banding | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 |
| % deaths with palliative care coded | 35 | 37 | 39 | 39 | 40 | 40 | 41 | 43 | 43 | 44 | 45 | 44 |




Dotted line = upper limit

## Mandatory Statement 18: PROMs

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

| Patient Reported Outcome Measures (PROMs) | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18^ | 2018/19 | 2019/20 | 2020/21* | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| **Groin Hernia** | | | | | | | | | | |
| **Dorset County Hospital** | **0.076** | **0.076** | **0.066** | **N/A** | **0.068** | **N/A** | **N/A** | **N/A** | **N/A** | |
| *National Average* | *0.085* | *0.085* | *0.084* | *0.088* | *0.086* | *N/A* | *N/A* | *N/A* | *N/A* | |
| *Lowest* | | | | | | | | | | |
| *Highest* | | | | | | | | | | |
| **Hip replacement** | | | | | | | | | | |
| **Dorset County Hospital** | **0.461** | **0.445** | **0.466** | **0.471** | **0.462** | **0.506** | **0.501** | **0.461** | **N/A** | |
| *National average* | *0.438* | *0.436* | *0.437* | *0.438* | *0.445* | *0.458* | *0.457* | *0.46* | *N/A* | |
| *Lowest* | | | | | | | | | | |
| *Highest* | | | | | | | | | | |
| **Knee replacement** | | | | | | | | | | |
| **Dorset County Hospital** | **0.304** | **0.297** | **0.305** | **0.341** | **0.299** | **0.356** | **0.361** | **0.36** | **N/A** | |
| *National average* | *0.318* | *0.323* | *0.315* | *0.320* | *0.324* | *0.337* | *0.337* | *0.341* | *N/A* | |
| *Lowest* | | | | | | | | | | |
| *Highest* | | | | | | | | | | |
| **Varicose Vein** | | | | | | | | | | |
| **Dorset County Hospital** | **N/A** | **N/A** | **0.099** | **0.127** | **0.043** | **N/A** | **N/A** | **N/A** | **N/A** | |
| *National average* | *N/A* | *0.093* | *0.095* | *0.096* | *0.092* | *N/A* | *N/A* | *N/A* | *N/A* | |
| *Lowest* | | | | | | | | | | |
| *Highest* | | | | | | | | | | |

***Latest provisional publication up to August 2020***
***^NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery national PROM collections from October 2017***
Source
https://digital.nhs.uk/patient-reported-outcome-measures

A higher number demonstrates that patients have experienced a greater improvement in their health.

## Mandatory Statement 19: Readmissions

The table below shows the percentage of emergency readmissions to the Trust within 28 days of a patient being discharged.

| Readmissions within 28 days | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|---|---|---|---|
| *Aged 0 to 15 years* | | | | | | | | | |
| Total Spells | 5,147 | 4,749 | 4,676 | 4,948 | 4,975 | 4,778 | 4,677 | 4,568 | 3,165 |
| Of which, readmitted as an emergency within 28 days | 456 | 393 | 442 | 471 | 488 | 478 | 508 | 573 | 372 |
| **Dorset County Hospital** | **8.9%** | **8.3%** | **9.5%** | **9.5%** | **9.8%** | **10.0%** | **10.9%** | **12.5%** | **11.8%** |
| *National average* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Lowest* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Highest* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Aged 16 years and over* | | | | | | | | | |
| Total Spells | 16,832 | 16,103 | 17,567 | 18,263 | 18,837 | 17,957 | 17,920 | 18,196 | 14,439 |
| Of which, readmitted as an emergency within 28 days | 1,741 | 1,695 | 1,994 | 2,222 | 2,295 | 2,142 | 2,316 | 2,504 | 2,087 |
| **Dorset County Hospital** | **10.3%** | **10.5%** | **11.4%** | **12.2%** | **12.2%** | **11.9%** | **12.9%** | **13.8%** | **14.5%** |
| *National average* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Lowest* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |
| *Highest* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* | *N/A* |

Source Internal DCH report which follows the guidance as stated on p22 of:
https://improvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor__qual_repts_16-17_.pdf
NHS Digital has not published the recommended source reports since December 2013

Recommended Source (not available - see comment below)
https://indicators.hscic.gov.uk/webview/
Section Compendium of population health indicators > Hospital Care > Outcomes > Readmissions
To find the percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of di
To find the percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days
**Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.**

**S:\Information\ICS Clone\28 Day Re-Admissions\QA_Methodology_Emergency_Re_Admissions.mdb**
**Amend dates in append query and run macro**

## Mandatory Statement 20: Responsive

The indicator is a composite, calculated as the average of five survey questions taken from the annual national inpatient survey.

| Responsiveness to the personal needs of patients | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21* | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| **Dorset County Hospital** | **66.9** | **69.9** | **71.1** | **69.6** | **70.2** | **69.0** | **68.2** | **67.0** | **N/A** | |
| *National average* | *68.1* | *68.7* | *68.9* | *69.6* | *68.1* | *68.6* | *67.2* | *67.1* | *N/A* | |
| *Lowest* | *57.4* | *54.4* | *59.1* | *58.9* | *60.0* | *60.5* | *58.9* | *59.5* | *N/A* | |
| *Highest* | *84.4* | *84.2* | *86.1* | *86.2* | *85.2* | *85.0* | *85.0* | *84.2* | *N/A* | |

***2020/21 data to be published August 2021***
Source
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/may-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

The overall score can range from 0 to 100, a higher score indicating better performance. If all patients were to report all aspects of their care as 'very good' this would equate to an overall score of 80. A score of approximately 60 would indicate 'good' patient experience.

## Mandatory Statement 21: Staff Friends and Family Test (SFFT)

*This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2020 survey.*

| Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Dorset County Hospital | 76% | **80%** | **78%** | **80%** |

| | | | | |
|---|---|---|---|---|
| National Average (median) | 71% | **71%** | **69%** | **74%** |

## Mandatory Statement 23: VTE

Venous thromboembolism (VTE) is an international patient safety issue and a clinical priority for the NHS in England.

VTE is a collective term for deep vein thrombosis (DVT) – a blood clot that forms in the veins of the leg; and pulmonary embolism (PE) – a blood clot in the lungs. It affects approximately 1 in every 1000 of the UK population and is a significant cause of mortality, long term disability and chronic ill-health problems.

| Rate of admitted patients assessed for VTE | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20* | 2020/21* | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | 24,026 | 87,426 | 91,462 | 96,063 | 96,797 | 98,692 | 99,443 | 59,516 | N/A | |
| Of which, VTE risk assessed | 22,077 | 85,211 | 87,371 | 92,847 | 92,813 | 94,793 | 94,133 | 52,933 | N/A | |
| **% VTE risk assessed** | **91.9%** | **97.5%** | **95.5%** | **96.7%** | **95.9%** | **96.0%** | **94.7%** | **88.9%** | **N/A** |  |
| *NHS Standard* | *92.0%* | *95.0%* | *95.0%* | *95.0%* | *95.0%* | *95.0%* | *95.0%* | *95.0%* | *N/A* | |
| *National Average* | *94.0%* | *95.8%* | *96.1%* | *95.8%* | *95.6%* | *95.3%* | *95.6%* | *95.5%* | *N/A* |  |
| *Lowest* | ***80.2%*** | ***66.7%*** | ***88.6%*** | ***76.9%*** | ***0.0%*** | ***75.1%*** | ***0.0%*** | ***71.8%*** | ***N/A*** | |
| *Highest* | *100.0%* | *100.0%* | *100.0%* | *100.0%* | *100.0%* | *100.0%* | *100.0%* | *100.0%* | *N/A* | |

***2019/20 nationally published data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic***

Source
https://www.england.nhs.uk/statistics/statistical-work-areas/vte/
https://improvement.nhs.uk/resources/vte/

There is no year end data as collection and publication was suspended in line with national guidance to release capacity within providers to support and manage the Covid-19 pandemic

## Mandatory Statement 24: C-Difficile

Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea. People who become infected with C. difficile are usually those who've taken antibiotics, particularly the elderly and people whose immune systems are compromised. For each hospital onset case (stool sample taken after day 2 of admission) a full route cause analysis is performed to identify any learning or lapses in care with particular attention on sampling in a timely manner, isolating patients with new onset of diarrhoea and justification of prior antibiotic use. Of the cases reported for 2019/20 half of the cases were deemed trajectory cases with learning identified and the other half were non-trajectory cases with no lapses in care found.

| C-difficile rates per 100,000 bed-days | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Bed-days | 101,156 | 102,674 | 98,654 | 105,719 | 99,883 | 98,908 | 98,845 | 100,903 | N/A | |
| C-difficile cases | 22 | 27 | 15 | 24 | 13 | 10 | 10 | 10 | N/A | |
| **C-difficile rate** | **21.7** | **26.3** | **15.2** | **22.7** | **13.0** | **10.1** | **10.1** | **9.9** | N/A | |
| *National Average* | *17.4* | *14.7* | *15.0* | *14.9* | *13.2* | *13.6* | *12.2* | *13.6* | *N/A* | |
| *Lowest* | *0.0* | *0.0* | *0.0* | *0.0* | *0.0* | *0.0* | *0.0* | *0.0* | *N/A* | |
| *Highest* | *31.2* | *37.1* | *62.6* | *67.2* | *82.7* | *91.0* | *79.7* | *51.0* | *N/A* | |

***2020/21 data currently not published***
Source
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

## Mandatory Statement 25: Incidents

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

| Patient safety incidents reported | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21* | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of patient safety incidents reported to NRLS | 2,945 | 1,736 | 2,116 | 4,609 | 4,493 | 4,838 | 4,997 | 5,542 | N/A | |
| Admissions | 51,184 | 50,530 | 98,666 | 105,413 | 99,883 | 99,491 | 98,845 | 100,903 | N/A | |
| **Incident rate per 100 admissions** | **5.8** | **3.4** | **2.1** | **4.4** | **4.5** | **4.9** | **5.1** | **5.5** | **N/A** | |
| *National Average* | *7.1* | *7.7* | *3.6* | *3.9* | *4.1* | *4.3* | *4.5* | *4.9* | *N/A* | |
| *Lowest* | *2.5* | *3.0* | *1.7* | *1.6* | *1.9* | *1.6* | *2.1* | *2.1* | *N/A* | |
| *Highest* | *27.8* | *30.4* | *10.2* | *13.0* | *14.8* | *16.7* | *14.2* | *18.1* | *N/A* | |
| Incidents resulting in severe harm or death | 25 | 3 | 19 | 25 | 24 | 22 | 25 | 28 | N/A | |
| **Percentage of incidents resulting in severe harm or death** | **0.85%** | **0.17%** | **0.90%** | **0.54%** | **0.53%** | **0.45%** | **0.50%** | **0.51%** | **N/A** | |
| *National Average* | *0.65%* | *0.55%* | *0.49%* | *0.41%* | *0.37%* | *0.34%* | *0.32%* | *0.30%* | *N/A* | |
| *Lowest* | *0.00%* | *0.00%* | *0.00%* | *0.00%* | *0.00%* | *0.00%* | *0.00%* | *0.00%* | *N/A* | |
| *Highest* | *3.34%* | *3.90%* | *4.18%* | *1.74%* | *1.58%* | *1.76%* | *1.35%* | *1.31%* | *N/A* | |

***2020/21 data currently not published***
Source
https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts/domain-5

The trust actively encourages staff to report incidents and ‘near-miss’ episodes to ensure that key learning points are shared throughout the organisation.

## Part 3 – Other Information

This section of the report provides further detail on the quality of services provided or subcontracted by the Trust in the period 2020/21.

## Patient Safety – Reducing avoidable harms from Hospital Falls

Due to the national directive, the Trust has concentrated its resources to the pandemic, however various Quality work has continued.

Actions have continued throughout 2020/21 and once the pandemic incident has been de-escalated, the Quality Improvement work will recommence as part of Patient Safety agenda

## Patient Safety – Improved Mortality Surveillance and Reducing Variation

What is mortality surveillance?

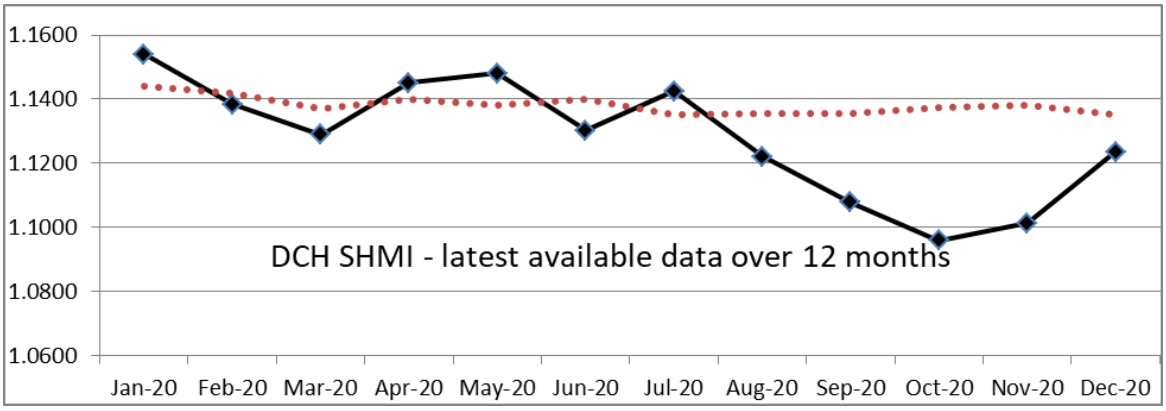
Mortality surveillance is the ongoing systematic monitoring and analysis of mortality data and the sharing of information that leads to actions being taken to address either data quality issues (the way information is documented, recorded and coded) or health concerns and delivery of care.

How did we perform?

The Trust has established robust mechanisms for the review of all in-patient deaths, as well as those occurring within 30 days of discharge, plus the associated data and coding, through the monthly Learning from Deaths Hospital Mortality Group. Team-based Mortality and Morbidity meetings also occur at departmental level.

The primary mortality indicator published nationally by NHS Digital is the Summary Hospital-level Mortality Indicator (SHMI) which reports at trust and site level across England using a standard and transparent methodology. SHMI is the ratio between the actual numbers of patients who died at the trust or within 30 days of discharge and the number that would be expected to die given the total coded risks of each inpatient's health status. It is reported 5 months in arrears so the latest data runs to December 2020. NHS Digital decided not to include any deaths related to COVID-19.

Figure 1 - SHMI trend (rolling 12 months, red dotted line = upper limit of expected range)




SHMI performance is constantly monitored against peers using nationally published reports. Although Dorset County Hospital Foundation Trust (DCHFT) had previously been consistently in the 'higher than expected' category since March 2017, the Trust has improved progressively throughout 2020, and the data is now consistently within the 'as expected' category. The latest data from NHS Digital was published in May 2021 for patients discharged between January 2020 and December 2020.

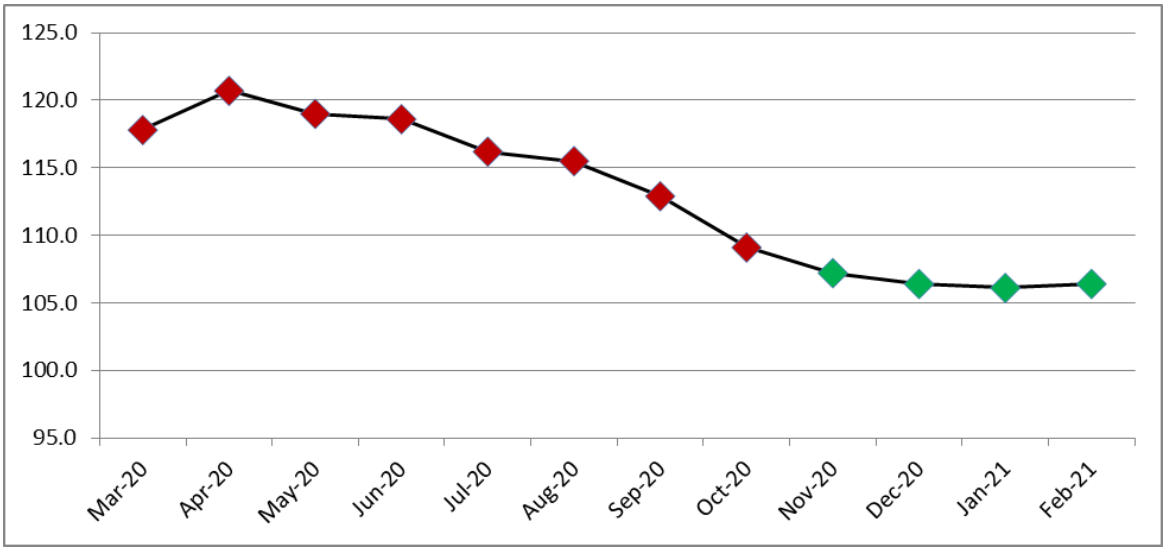
The Trust had previously identified that the depth of coding (the number of secondary diagnosis codes per finished provider spell) could have been having an adverse effect on the SHMI. In NHS Digital's latest reports DCHFT has seen progressive improvement in the mean depth of coding for both elective and non-elective spells. In particular mean depth of coding for non-elective (emergency admission) patients has increased from 3.7 to 5.8, slightly above the national average. Depth of coding contributes significantly to the accuracy of both SHMI and HSMR.

The Trust uses benchmarking software from Dr Foster to facilitate more in-depth analysis of mortality data and also enables the Trust to monitor another nationally recognised mortality index – the Hospital Standardised Mortality Ratio (HSMR). The key differences in methodology between the two indicators are:

- SHMI includes all spells, while HSMR includes a basket of 56 diagnoses (around 85% of deaths).
- SHMI includes post-discharge deaths within 30 days (which requires linkage to Office for National Statistics that incurs a time lag), while HSMR focuses on in-hospital deaths only.
- HSMR is adjusted for more factors than the SHMI, most significantly palliative care but also including CCS sub groups, social deprivation, past history of admissions, month of admission and source of admission.

- SHMI attributes a death to the last episode within an acute non-specialist trust, whereas the HSMR attributes a death across a continuous in-patient spell.

Figure 2 – HSMR trend (rolling 12 months)




In parallel with the improvement in SHMI and coding, HSMR has fallen to within the expected range for each of the four latest publications to February 2021.

## Patient Safety – Improving early identification and treatment of Sepsis (All cause deterioration)

Goal for 2020-2021:

Due to national directive to concentrate resource to the pandemic effort, audits were paused in 2020/21.

All Cause Deterioration Pathway - in response to themes arising from incidents reported and SJRs around failure to recognise and escalate the care of the deteriorating patient, an All Cause Deterioration Pathway is being introduced across the Trust. These forms should improve early and appropriate escalation of the deteriorating patient and therefore improve patient safety and quality of care. The form was developed by the Regional deteriorating patient network overseen by the Wessex AHSN and then localised to DCH.

The pathway has been approved by the Deteriorating Patient Group and has been successfully trialled within both medicine and surgery, with positive feedback from doctors and nurses. Feedback states that the pathway does not increase any burden of paperwork and provides a supportive and easy to follow route to getting the right help for patients. The intention is for these forms to roll out across the Trust by early summer.

There are two documents:

The All Cause Deterioration Pathway; a clear concise, user friendly flow chart/ pathway to aid in the process of escalation.

The Clinical Deterioration Episode; a proforma, which is commenced by the nursing staff following a new NEWS score of 5 or above, documenting the NEWs score, time and who the patient has been escalated to. The form then goes into the patient notes to be completed by the first responder, either doctor or ANP.

## Clinical Effectiveness – Promoting the Health and Wellbeing of staff

**Promoting the Health and Wellbeing of staff**

Goal 2020-2021: Staff can access quality information to look after their health and wellbeing, and can get support when they need it.

**Why is the Health and Wellbeing of our staff important to delivery of outstanding care?**

The Trust recognises that its employees play a vital role in its aim to provide 'outstanding care for people in ways which matter to them'. The evidence shows that when our staff feel well and satisfied with their work, the experiences of our patients improve. It makes sound business sense to ensure all our staff can access timely, relevant and evidence-based information to maintain their wellbeing, and can get support when they need it.

**How did we perform?**

We offer the current initiatives:

**Staff Intranet & Staff App**

The Health and Wellbeing pages of our intranet and Staff App are regularly updated with all relevant information for staff to access 24/7.

**Health and Wellbeing Champions**

We have 20+ staff Health & Wellbeing Champions across the trust. They have volunteered to support and publicise events and initiatives which benefit the health and wellbeing of staff, and provide a way for staff to feedback their experiences. A monthly Champion Newsletter updates them on the latest wellbeing news and services. They will be offered training by Livewell Dorset in 2021-22 on the importance of physical activity and how to support colleagues and patients to make healthy lifestyle changes.

**Occupational Health & Wellbeing**

The role of the Occupational Health (OH) and Wellbeing Service is to act in an advisory capacity to both staff and managers to promote and maintain the highest possible levels of health and wellbeing in the workplace. The OH and Wellbeing service is both confidential and impartial.

**Employee Assistance Programme (EAP) - Care First** (to be replaced by Vivup in May 2021)

Care First is a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues.

All staff can access Care First confidentially on the phone 24 hours a day. They provide additional support in both work and non-work related matters. From work-life balance to childcare information, relationships to workplace issues, health & wellbeing. Topics include (but are not limited to) Debt, disability & illness, bereavement & loss, stress, elder care information, life events, anxiety & depression, family issues, education and consumer rights.

In May 2021 our EAP provider will be Vivup who offer all of the benefits listed above with the addition of a full benefits package including Cycle to Work, Travel & Leisure and access to a huge range of discounts across UK's major retailers.

Our I&W lead works closely with Care First/Vivup to ensure they can give our staff up to date information about local services and support.

**Physiotherapy**

All staff can access physiotherapy services via self-referral or through their line manager.

**Emotional and Mental Wellbeing**

The Trust values both the physical and mental health of our people. We believe that work should be a positive part of our lives, and strive to enable our staff to ensure they have the skills, knowledge and resilience to maintain their wellbeing, as well as knowing how to seek help when they need it by:

- **Raising Awareness and improving Mental Health Literacy:**

The Trust has 3 in-house Mental Health First Aid (MHFA) Instructors qualified to deliver Mental Health First Aider (MHFA) 2 day, 1 day Champion and half-day Awareness sessions to our staff and partners. We currently have 62 MH First Aiders and continue to recruit from all teams, targeting particularly vulnerable groups such as junior doctors.

- **Providing peer support and signposting to timely and appropriate help:**

We have a newly established MHFA network, which offers our MHFAiders a safe space to meet and provide peer support and informal supervision for each other, along with refreshing their learning and developing their skills.

- **Ensuring staff who are unwell receive the support they need:**

The Trust provides confidential access to both telephone and face to face counselling services for all employees, via our Employee Assistance Programme Care First (and from May 21, the provider will be Vivup) and via our on-site counselling provision who provide a 7 day service.

- **Psychological First Aid**

A 60 minute session focusing on self-care and peer support, particularly how to look for signs of psychological distress and potential trauma in self and others, has been delivered to a number of teams across the Trust and received excellent feedback.

- **Wellbeing Walkrounds**

Regular walk-arounds to visit as many teams as possible with support from the Freedom To Speak Up Guardian, H&W Champions and MHFAiders. Feedback from staff during phase one suggests a regular presence from members of the Executive team would boost staff morale and alleviate anxieties around uncertainty, so this was implemented.

**Financial Wellbeing**

Neyber, a financial wellbeing service has been available to staff since February 2019, with a financial wellbeing portal offering free financial planning tools.

We are looking to add bespoke financial wellbeing & planning sessions to staff e.g. benefits of NHS pension scheme for new/younger staff in 2021-22.

**Pre-Retirement Planning**

The Trust offers Pre-Retirement sessions for staff thinking about retiring in the next 3-5 years. These are delivered by Affinity Connect, and offer the opportunity to start looking at all the various options available and planning for the future. This session also includes information from Livewell Dorset on the importance of remaining active in the retirement years and the health benefits of doing so.

**Chaplaincy Service**

Chaplains are employed by the Trust to provide confidential support and pastoral care to patients, carers and staff. This support is completely confidential and available to people of all faiths and none.

The Prayer Room is also available at all times of the night and day as a place of quiet reflection and prayer.

**Covid - workforce support**

At the start of the pandemic a comprehensive suite of COVID training packages were devised and rolled out at pace, helping clinical staff to feel adequately prepared for the challenges ahead. Changes to working practices were also implemented very quickly, including permitting those who were able to work from home to do so. Latterly, whilst responding to wave two of the pandemic, the Trust successfully set up and ran a Hospital

Vaccination Hub, delivering in excess of 20,000 vaccines to Health and Social Care staff from the West of the county, including our own staff at DCH.

## Patient Experience – Improving the identification, assessment and referral for patients with Dementia

**Quality account 2020-2021**

Over the last year Dementia screening has continued to fluctuate across the trust. Patient key workers within the medical division are assisting with this, however they on not on all wards. The Comprehensive geriatric assessment (CGA) is still a work in progress but electronic solutions are now a real possibility with the Agile software being developed. The Trust awaits the update to vital Pac to include the 4 A's Test (4AT) and delirium screening. Plans to recruit 2WTE Support workers to assist the dementia screening have not gone ahead due to funding.
Throughout the pandemic the Advance Nurse Practitioner (ANP) for Dementia/Frailty was ward based in order to support a cohort of dementia patients as well as compliment the medical and nursing staff. Referrals continued to be accepted from across the hospital but these were at a lesser rate.
ANP for Dementia/Frailty continues to deliver education on Dementia, Delirium and behaviours that challenge to preceptorship students, medical training and offers bespoke training to ward teams.
Currently working on a frailty strategy with the wider MDT in order to provide an equitable service across the trust.

## Patient Experience – Improved Learning from Complaints

Goal 2020-2021:

We will ensure that we learn when our patients tell us they have not had a good experience with us.

**Complaints during COVID- 19:**

At the end of March 2020 there was a national pause of NHS Complaints as we entered a lockdown situation due to the COVID-19 (Coronavirus) pandemic. The Trust wrote to all existing complainants to explain that due to the pandemic the clinical staff would not be able to continue to investigate their complaint. We explained that the investigation would continue once the clinical staff were in a position to continue with complaint investigations but we were unable to give a timescale for their response letter. The national pause on NHS Complaints ended on the 1st July and new complaints received from the 1st July 2020 were given a 40 working day response timeframe which was agreed by both Divisions. This enabled the Trust to respond to those complaints in a realistic timeframe due to the demands on the clinical staff during the past year.

During the lockdown period the Patient Experience Team were and continue to work remotely with 2 staff on site in order to comply with social distancing guidance. We stopped face to face meetings with patients and visitors and all enquiries were dealt with via email or telephone.

We entered further lockdowns in November 2020 and January 2021 with the second and more demanding wave of Covid-19 (Coronavirus) during December/January 2021. During this second wave we explained to complainants that there may be a delay in responding to their complaints due to clinical staff being unavailable to complete complaint investigations. Where possible, we continued with complaint investigations and provided responses during the lockdowns.

During the recovery period we will continue with the 40 working day response timeframe and review this with the Divisions in 6 months. This will continue to be monitored via the Patient Experience Group quarterly reports.

**Why is learning from complaint important?**

Complaints are an important way for the management of an organisation to be accountable to the public, as well as providing valuable prompts to review organisational performance and the conduct of people that work within and for it.

A complaint is an expression of dissatisfaction made to or about an organisation, related to its products, services or staff.

An effective complaint handling system provides three key benefits to an organisation:

- It resolves issues raised by a person who is dissatisfied in a timely and effective way;
- It provides vital information that can lead to improvements in service delivery
- Where complaints are handled properly, a good system can improve confidence in an organisation's administrative processes.

The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints in order for the organisation to learn from what has happened to them. In order for them to be assured that the Trust has taken their complaint seriously and taken the opportunity to learn from their complaint, the learning points are included in the complaint response. These learning points are owned by the Division and form part of the Divisional quality improvement plan.

**How did we perform?**

Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings, in grand rounds, during junior doctors training, sisters and matrons meetings and porters & housekeeping briefings. Support is provided by the Patient Experience Team which enables them to understand the emotional

experience from the complainant and staff perspective and reflect upon improvements in relational aspects of care.

Patients have assisted in making videos narrating their experience of the care that they received, and also their feelings about the complaints process. These videos are shown to the relevant divisional leads and are available for presentation at Board when required. The creation of patient video stories has been paused during the Covid-19 (Coronavirus) pandemic and will resume in the coming months.

Complaints are an integral element of improving the patient's overall experience of health care and help to ensure that safe, high quality care is provided within the hospital. Learning from complaints is included in response letters to provide assurance to complainants that their complaint has been worthwhile, is taken seriously and the learning as a consequence in improving services/departments in the organisation

**Trust wide Performance**

In light of the Covid-19 pandemic and the national pause of NHS Complaints, much work has been undertaken in the last year to improve the management of complaints particularly the learning opportunities that occur when a complaint is made.

Learning and actions from complaints are monitored through the Divisions and Care Groups and where appropriate learning is shared across the organisation. Examples of learning from complaints are included in the quarterly Patient Experience report and reviewed by the Quality Committee.

Although we have made progress in learning from complaints, there is still some way to go to fully embed and monitor learning from complaints in the Trust and this will be our focus for the next year. From April 2021 actions and learning will be allocated using the Datix system to support the Divisions and Care Groups in the monitoring and completion of actions/learning from complaints.

## Patient Experience – Improving the support from Hospital Volunteers to have positive effects on clinical outcomes

**Goal for 2020/21**

The goals for the reporting period above were set as a continuation from those set in 2019/2020. As we approached the start of the 2020/2021 reporting period we of course were affected by COVID-19 and this has understandably had an unforeseen impact on the volunteer service and our objectives. This report focuses on what we have done to adapt over the last 12 months and what ultimately has enabled the volunteer service to support the Trust and continue to run despite the challenges and restrictions we have been faced with.

The three Key goals for the service are as follows:

1. **Young Volunteer Programme**

We will continue to build our Young Volunteer Programme (YVP) in line with the, Pears #iWill Fund, beacon area commitments focusing on both Volunteer Opportunities within the Trust and community engagement projects.

2. **Volunteer Development**

We will continue to development our volunteer service with focus on building a Response Volunteer Team for which we have been awarded funding for through the NHSEI Voluntary Partnerships winter funding programme.

3. **Volunteer Experience**

We will continue to work with our Volunteers to ensure the volunteer experience at DCH is a positive one, developing the Induction Package for new volunteers and our programme of thank you and recognition events.

**How did we perform?**

**Young Volunteer Programme**

The government restrictions put in place through COVID-19 meant that all the plans we had in place for our Young Volunteer Programme in 2020 came to a grinding halt overnight! We have however continued to stay in touch with our local Youth network and when we are able to proceed with this part of the programme we will. The Pears foundation have given approval for us to run the funding in to 2021/22 and continue to be fully supportive.

Despite the restrictions we have however been supporting Young Volunteers within the hospital and have supported a team of volunteers who have joined our response team and been incredible over the last year. Some were existing volunteers, but we also recruited some young volunteers who were able to fit in volunteering around online schooling. They worked with the rest of the team through April to August, supporting largely with the PPE packing and distribution and donation sorting and distribution. Some of the team then went back to support inpatient wards once they were allowed and they continue to carry out shifts with many also involved in supporting our COVID-19 Vaccination hub. We have had some fantastic feedback from the wards on how much support they give. For example, please see below feedback received from a sister on Purbeck ward regarding one of our Young Volunteers:

*"I would just like to express how much we appreciate all our volunteers here on Purbeck Ward. They are a highly valued and much loved part of our workforce. I would like to highlight the efforts of Violet in particular, she has never failed to turn up on a Saturday, even on Boxing Day! She has no fear of chipping in and she is quite willing to sit with our confused or lonely patients and give them time and the opportunity to talk. We have had some shifts that without her assistance would have been much harder. And to think she's only 17 and does not get paid to be here, she and the rest of the volunteers are truly amazing".*

Whilst we are not in a position yet to proactively recruit, we are responding to enquiries and since January this has included recruitment of a further 11 Young Volunteers. We hope to reinvigorate the programme through the stat of the 2021/22 year with further recruitment and running a summer volunteer activity programme before looking at our community engagement projects with Young People from September 2021.

**Volunteer Development**



2020/21 was planned to be an exciting year for us with the launch of our Response Volunteer Team (RVT) which we had started to pilot in January 2020. This would see us focus our volunteer service on supporting Patient Flow and Discharge providing volunteers when they were needed and where they were needed as opposed to attaching a volunteer to one department. This project was being run as already mentioned with thanks to funding from NHSEI Voluntary Partnerships and we were one of a network of Trusts across the country which had been awarded the funding. The funding enabled us to recruit a Volunteer Administrator to our team whose position has since been made permanent by the Trust. We were awarded further funding in November 2020 through voluntary partnerships to expand aspects of our Response service and we will using this to support development in the 2021/22 year.

COVID-19 resulted in us suspending many of our volunteer roles by April 2020, this included our RVT which was largely focused on inpatient support and so would no longer be possible given the restrictions in place to protect against COVID-19 infection and transmission. By the start of April approximately 95% of our volunteers had to stop volunteering to shield in line with government restrictions. However, following guidance from NHSEI Voluntary Partnerships we took the decision not to suspend all volunteering and worked with departments across the hospital to identify need for volunteer support. By the middle of April we had stood up a RVT with some very different tasking to what was originally planned, taking on responsibility for the packing and distribution of Surgical Masks and all donations coming into the hospital. We recruited a small number of volunteers to support those who were able and willing to continue volunteering and deploy into the newly formed RVT. Whilst Response Volunteering was part of the plans for 2020 we were working in a very different way to what had been planned and it saw volunteers work closer together than ever before. Volunteers gave up numerous hours of their time to support this and have remained flexible and patient throughout the last year. It was busy and has been busy since and the tasks we have carried out have developed and changed to continue to meet the need. To ensure we could do what was needed, recruitment processes were adapted and to support safety measures in place across the hospital we have only recruited new volunteers as needed.

As we adapted to working in a very different environment, we gradually saw requests to support again in former and new areas. Working with our RVT therefore we have been able to shape how the Response role looks and this has been the key focus for us since July / August 2020. We have been able through this process to look at former roles and how these can best be delivered and this has seen an amalgamation of some roles and a different model used to achieve role objectives.

By the end of March 2021 the response team comprised of three key roles,

- Healthy Hospital – Tasks supporting the hospital – i.e. PPE distribution and COVID Vaccinations but with a view that this will develop moving forward to include the 2019 (Pre-COVID) objective of supporting patient flow and discharge.
- Healthy Stay – Supporting patients on In Patient Wards and ED.
- Healthy Visit – Supporting Patients coming in for Outpatient appointments and visitors combining our former Guiding and Patient Liaison Roles. This also currently supports the Dialysis Unit every morning to support the changeover of patients between AM and PM.

Alongside this our Patient Research Ambassador Volunteers and Your Voice group volunteers are also active but largely offsite. We are also supporting other departments to resume roles including the Chaplaincy Assistants and the Friends of DCH. Communication continues with our inactive volunteers who are still shielding.

The table below gives an approximate indication of volunteer status by end of March 21.

| Volunteer Status – Up to 31 March 2021 | | | |
|---|---|---|---|
| Total Active Onsite (including Young | Total Currently Active Offsite | Total Inactive (including the | Total Young Volunteers |

| volunteers) | | FDCH) | |
|---|---|---|---|
| 71 (approx. 17 not currently regularly volunteering – due to temporary role suspension or external factors – i.e. school / re-shielding) | 16 | 174 (115 = FDCH) | 28 (13 not regularly volunteering) |
| **Volunteer Role Status – 31 March 2021** | | | |
| **Active Roles** | | **Inactive Roles** | |
| • Response<br>• Patient and Public Engagement (Your Voice)<br>• Patient Research Ambassadors<br>• Specific Activity (Gardening / ICT) | | • Chaplaincy Assistant (currently suspended)<br>• Specific Activity (PAT dogs and music)<br>• Play Assistant<br>• Friends of DCH | |
| **Volunteer Hours - 01 January - 31 March 2021** | | | |
| **Vaccination POD** | **PPE Distribution** | **Healthy Stay** | **Healthy Visit** |
| 1217 | 315 | 663 | 621 |
| Total Hours (approximate and reflective only of above active on-site roles) | | 2816 | |

**Volunteer Experience**

Our plans for thank you events and awards and recognition like so many of our other plans were put on hold through the 2020/21 reporting period due to COVID-19. However we have worked extremely hard as a team to support our volunteers as much as we can and through the incredible support they have given over the last year I think it is fair to say that their profile as a team in the Trust over the last year has never been so high. Supporting teams and departments that we have not done previously and ensuring they have an identity through provision of their Volunteer Uniform has resulted in increased acceptance and understanding of the volunteer roles and we have had some fabulous feedback from across the Trust. Despite not being able to hold our Summer Tea Party and Mince Pie Mingle in 2020 we were able to say thank you to our team regularly throughout the year in other ways from social media 'shout outs' to decorating the volunteer hub for Halloween. They have also been completely included in Trust wide initiatives to say thank you for the huge efforts made over the last year which has been greatly appreciated.

The provision of a volunteer hub ensured our RVT were able to have a base from which to carry out their tasks last year. This unfortunately was taken away just before Christmas as the space was reallocated. Space for a volunteer hub therefore remains the biggest challenge for the team. Since January the Volunteer hub has been working out of the Friends Shop. This has enabled us to continue to support the Response team and the hospital. At the time of writing this report we have had to vacate the shop with the Trust now working to secure a new space for the team having recognised the need for a permanent volunteer hub in order for us to continue to operate the Response service and develop its support. The hub is temporarily located in the porta cabin which was used as part of the vaccination POD and whilst logistically this creates additional challenges for the team it has allowed us to continue to run a service although with some restrictions. We hope that by the time of our next report we will be able to say we have a permanent base for our volunteers and we know that this will make a huge impact on supporting their volunteer experience.

To support what we are doing to ensure a positive volunteer experience, we have worked more closely with the NHS voluntary services network to ensure best practice and share ideas to support our volunteers. We have set up a return to volunteering process to ensure any volunteers coming back to volunteering have a full safety briefing and have completed required paperwork and training prior to returning. Recruitment opened up again properly in January which has seen new volunteers join the response team giving it a much needed boost as demand for volunteer support has increased. The team now support and manage the volunteers more closely than ever before essentially providing the volunteer management for the response team.

The health and wellbeing of our volunteers has been a priority for us this year and it has been important to ensure the voluntary services team have been available for them and be present so that they can talk to us about anything which they are worried or concerned about within the hospital and also just to allow them a chance to process what has become a challenging time for us all. They have given so much over the last year and done so with a smile on their faces but it's also been a time where we have seen lots of anxiety so we have wanted to ensure we can do everything we can to support their health and wellbeing. As well as ensuring we are accessible, we also send out weekly Trust communication updates to the team and ensure we include any health and wellbeing updates on this. As a team volunteers are working more closely together than they have done previously and this has been really positive as they have formed their own friendships and support network.

**Summary and the Year ahead**

Reimagining is a word being used widely now across the volunteer sector as we look at how 'volunteering' can be best delivered and managed in the future. We have certainly had to do this and will continue to do this. 2021/22 will see us recommence plans for our Young Volunteer Programme and continue to develop our Response Service alongside working with other Volunteer services within our ICS to develop consistent practices and implement new volunteer management software. Capacity to continue and expand will depend on the current situation with the volunteer hub but we are continuing to plan and will continue to be flexible and adapt to the need and work to build and strong resilient team of volunteers who make a difference and love volunteering at DCH.

## Risk Assessment Framework and Single Oversight Framework Indicators

The following indicators are a pre-requisite of the Risk Assessment Framework and the Single Oversight Framework to be included by Acute Trusts. More up-to-date data and fuller analysis and narrative is available on the Trust website in the Trust Board papers.

**RTT** - In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

**ED 4 hour target** - A four-hour target in emergency departments was introduced by the Department of Health for National Health Service acute hospitals in England to state that at least 95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.

**62 day wait** - All patients who have been referred by their GP or by a dentist on a suspected cancer pathway should receive their first definitive treatment within 62 days of referral receipt or a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer.

| Indicator | Standard | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway | 92% | 95.5% | 94.9% | 93.7% | 92.1% | 87.6% | 85.3% | 81.6% | 70.6% | 47.9% | |
| Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (ED Only) | 95% | 96.5% | 94.7% | 94.9% | 94.1% | 93.2% | 95.0% | 90.5% | 82.9% | 87.6% | |
| Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (Including MIU/UCC from November 2016) | 95% | 96.5% | 94.7% | 94.9% | 94.1% | 95.2% | 97.6% | 95.5% | 91.8% | 92.8% | |
| 62 day wait for first treatment from an urgent GP referral for suspected cancer | 85% | 93.4% | 88.4% | 85.5% | 81.7% | 86.2% | 80.5% | 77.9% | 78.4% | 72.9% | |
| 62 day wait for first treatment following a NHS Cancer Screening Service referral | 90% | 96.8% | 96.0% | 98.2% | 94.9% | 83.2% | 96.2% | 93.8% | 72.8% | 64.1% | |
| C-Difficile infections^ | 16 | 22 | 27 | 8 | 10 | 7 | 8 | 3 | 13 | 22 | |
| SHMI | 1.00 | 1.07 | 1.11 | 1.10 | 1.16 | 1.12 | 1.17 | 1.19 | 1.13 | Published Aug-21 | |
| Maximum 6 week wait for diagnostic procedures | 99% | 99.3% | 93.9% | 94.8% | 98.8% | 93.0% | 91.2% | 86.2% | 91.5% | 64.7% | |
| VTE Risk assessment~ | 95% | 91.9% | 97.5% | 95.5% | 96.7% | 95.9% | 96.0% | 94.7% | 88.9% | N/A | |

Target achieved
Target not met

*^pre 2019/20 criteria based on hospital acquired cases (post 72 hours) due to lapses in care, from 2019/20 onwards hospital onset healthcare associated cases defined as those detected in hospital three or more days after admission*
*~2019/20 nationally published VTE data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic*

# Annex 1 Statement from Commissioners, Local Healthwatch and Overview and Scrutiny Committees

## HealthWatch

No requirement for a statement from Healthwatch Dorset is required as per National Guidance.

## DCHFT Lead Governor Commentary on the Trust Quality Report 2019-2020

No commentary  required as per national guidance

## Statement from CCG

Draft statement has been sent to the CCG and we await a response

## Statement from Health and overview Scrutiny Committee

No statement required as per National Guidance

## Annex 2 Statement of Directors' Responsibility for the Quality Report

Following National Guidance supporting Covid-19 pandemic response. This report has been written to the best of the Trusts abilities

By order of the board:

Mark Addison
Chairman

Patricia Miller
Chief Executive

**INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT**

No statement is required as per National Guidance