#表演报告

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**作者**
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**报告目的**
更新管理委员会对多塞特系统当前表现问题的了解。

**建议**
管理委员会被要求认识到这份报告。

**利益相关者参与**
N/A

**之前GB/委员会/日期**
N/A

## 监控和保证总结

此报告链接到以下战略目标
- 预防规模化
- 整合社区和初级保健服务
- 一个急症网络
- 数字化多塞特
- 领导和以不同方式工作

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我确认我考虑了这份报告对上述事项的影响，如表示。

**注意事项**

- 可以复制粘贴打勾

**附件**

**初始**
SAB
1. Introduction

1.1 Throughout pandemic contractual data flows remained in place. However, the six week lag inherent in these did not provide leaders in the health and care system with timely enough information to support decision-making.

1.2 Locally partners agreed greater and more timely data flow between organisations to support co-ordinated action to manage pandemic.

1.3 This resulted in the production of the Covid-19 dashboard which was well received and continues to be used.

1.4 The system agreed its aspiration was to build on this approach to develop and provide a consolidated timely picture of how the Dorset system is operating with a focus on supporting recovery rather than contractual performance.

2. Performance Reporting

2.1 Not all data flows are yet in place, but good progress has been made in towards achieving overnight activity count metrics for all acute trusts by mid-July.

2.2 Work is underway to increase the information on mental health and community services which is currently not visible.

2.3 Chief Operating Officers will work with the CCG to co-design the report content and visuals.

2.4 Appendix 1 uses a variety of data sources to inform Governing Body Members of the key issues within the Dorset system.

3. Performance Highlights

3.1 There was significant growth in telephone appointments and the use of video consultation and e-consult triage in primary care offsetting the reduction in face to face appointments. However, face to face appointments themselves have doubled from their low point in early April.

3.2 Primary care networks identified priorities around “living with Covid” and business continuity as well as embedding digital technologies (including funding).

3.3 Feedback from NHS England Elective leads is that overall Dorset did well in the level of elective care it maintained during the height of the pandemic. This was driven largely by performance in outpatients - well supported by digital options.

3.4 Overall elective waiting list numbers fell between February and May though in large part of this can be attributed to lack of patient presentation in primary care and the request from secondary care that only urgent referrals were made.

3.5 However, during the same period, the number of patients waiting over 52 weeks rose from just under 100 to just over 1,000. The most significant areas are orthopaedics, ophthalmology, general surgery, and oral (maxilla facial) surgery.
3.6 Diagnostic performance considerably worsened. Appendix 1 includes extracts from the diagnostics dashboard for endoscopy, imaging, and physiological measurement.

3.7 Endoscopy is significantly under pressure with insufficient capacity and growing demand pre-Covid, exacerbated by paused lists and the very significant process changes associated with infection prevention and control for this specialty.

3.8 All four providers in Dorset are working together through a clinical network led by Alastair Hutchison (Medical Director at Dorset County Hospital). Bids are being developed for capital investment to support greater capacity.

3.9 Whilst use of the independent sector is considered reasonable regionally there is some capacity remaining unused. The most significant barrier to expanding this use is medical cover overnight. There is currently not thought to be enough medical capacity to cover the independent sector providers (ISPs) as well as the NHS hospitals.

3.10 Type 1/2 attendances at emergency departments have remained at lower levels than in the previous year though the trend is clearly a return to pre-Covid levels.

3.11 Type 3 Minor Injury Units (MIU) activity shows a less consistent trend and somewhat less of a return to pre-Covid levels perhaps driven by the need to “book”. This may be encouraging some people to walk into E.D. Ensuring maximum use of MIUs will support greater E.D. efficiency, social distancing and improved ambulance handovers. Work is underway to review and revise the model if appropriate.

3.12 Work is also underway in developing an integrated Urgent and Emergency Care (UEC) along the whole pathway. This work requires significant demand capacity modelling not yet secured.

3.13 Occupancy and length of stay in hospitals are rising. This will be one of the elements addressed through the recently agreed “Home First” programme.

3.14 Cancer referrals reduced by around 40-50% since pre-COVID with the highest reduction in lung cancer.

3.15 Actions being taken through the Dorset Cancer Partnership (DCP) include lung cancer case finding in primary care, public awareness raising of signs and symptoms, videos by clinicians to the public, Help us to Help you campaign, new COVID-19 2ww referral letter, comms to GPs, hospital discussion with patients about risk vs benefits.

3.16 Of all patients deferred at diagnostics, most are waiting for endoscopy. The DCP is supporting the emerging endoscopy network and working strategically with Wessex to identify solutions. They have also introduced Faecal Immunochemical Testing in secondary care.
4. Conclusion

4.1 Dorset made progress on shared understanding of how the system was operating under Covid. The learning will be built upon to develop better reporting on operational performance. Developing greater data flows and reporting on community and mental health services will be key to providing a full picture.

4.2 Key areas for development identified through Chief Operating Officers to date are shown below (not all are as yet covered by system wide performance reports).

- Primary care business continuity supported by investment in digital technologies
- Community Pathways in and out of hospital (including risk stratification and discharge arrangements “Home First”)
- MIU model to support ED demand
- Elective and diagnostic capacity in Endoscopy, Orthopaedics, Ophthalmology, General Surgery, ENT, and Oral Surgery.
- End to end design of a single outpatient model
- Expansion of Critical care capacity- beds, rehab, transport
- Mental health- Steps to Wellbeing capacity, psychiatric liaison and bed capacity

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<table>
<thead>
<tr>
<th>APPENDICES</th>
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<tr>
<td>Appendix 1</td>
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Dorset System Performance
3rd July 2020
Background and context

- Throughout pandemic:
  - Contractual data flows remain— but with up to 6 week lag
  - Locally partners agreed greater and more timely data flow between organisations to support coordinated action to manage pandemic— including cc’ing national SITREPs

- Demonstrated via production of Covid19 dashboard

- Aspiration to build on this approach to develop and provide consolidated timely picture of performance
System Performance Report - Plan

- Use learning from Covid Dashboard development to inform better data and better presentation of the data
- Currently not fully developed
- Only contains Bournemouth and Poole and Dorset Healthcare data where this already flowing for Covid 19 Dashboard
- Remainder of this pack based on screen shots from a number of source dashboards
- Aspiration to have live version of this for OFRG.
- Pages will support different preferences by enabling toggling between graphical tabular and SPC presentations
Primary Care

- F2F appointments significantly down on 19/20 but have doubled since 01/04 (approx. 35k most recent week)
- Telephone appointment sustaining significant growth on 19/20 level (29k in most recent week)
- Use of E-consult (clinical triaging software) up from 5k Jan 20 to 18k events in May.
- In total 7k fewer appointments than 19/20 due to some from some suppressed demand - however note that but not all alternatives (e.g. AccuRX or E Consult) yet feeding into overall figures
- Recovery being developed and managed on PCN basis.
- Priorities
  - Developing tactics for “Living with Covid” & Business Continuity managing with reduced capacity-balancing expectations of system/NHSE/I and their own patients.
  - Utilising Digital technologies – and their recurrent funding this is definitely a challenge.
Summary Elective Picture at the end of May

- Manual data collection presented in very basic format - nevertheless highlights areas of variation and similarity
- CCG Chair shared with clinical cell – responded with strong support from those present for a single Dorset approach to waiting lists (and all indications from NHSE/I is that we should plan as a “system by default”)
- OFRG agreed to wider daily data flow to support better system wide oversight of activity and waiting list to support recovery.
Outpatient Alternatives to Face to face Attend Anywhere-all activity
Actions agreed: RBH/PGH – agreed £1m investment to make 2 locums substantive at RBH sourcing lists from both RBH and PGH until end July plus mobile unit for 3 months

Proposals:
- Re-task endoscopy network to develop solutions
- Explore if wider use of FIT and CTC beneficial/viable
- Review new national pathways (capsule endoscopy)
- Single waiting list and establish a real time scheduling tool
Imaging (as at end of April)
Physiological Measurement (as at end of April)
**Elective Activity**

1. Insufficient data to report on beyond May - already reviewed via OFRG. However problem areas are well rehearsed.

   - Endoscopy
   - Orthopaedics
   - Ophthalmology
   - General Surgery
   - ENT
   - Oral Surgery

2. Actions which need to continue - and possibly grow -
   a) Clinical triage (happening throughout Covid)
   b) Continue OP appointments through Attend Anywhere where possible
   c) PIFU – reducing those needing appointments (following a clinical assessment/triage as suitable for PIFU)
   d) Proactively promoting health support while patients are waiting; Health Care innovations, physio self-referral, ORCA

3. Potential further actions required
   a) System approach to use of Dorset ISPs to maximise use and ensure equity. ISPs could operate till 8p.m. but medical cover is an issue
   b) Access ISPs outside of Dorset. Some resistance from other commissioners. Use as a system - SMTC may have capacity in 6 weeks time
   c) Mobile units: as a dry shell or equipped. Most used for diagnostics, chemotherapy, ophthalmology (macular). Little surgery carried out but not impossible to adapt (e.g. for cataract) depending on space needed, time for recovery etc.) Usually a minimum 3 month hire. RBH has commissioned a mobile unit to support endoscopy.
   d) Lead providers per speciality with responsibility for coordinating all capacity
   e) Further insourcing – possible but probably limited as staff by NHS staff out of hours and all providers are ‘fishing in the same pond’
   f) Commission purpose-designed standalone cataract unit for the county (high volume, day case)
   g) Commission standalone outpatient unit (would need to resolve what would happen to existing one stop services, includes easy surgery?)
   h) Review of all procedures to ensure there isn’t a first line of treatment/alternative that hasn’t been considered/is more appropriate
   i) Conversations with neighbouring trusts/CCG in Hampshire/Somerset re sharing capacity?
### Independent Sector Utilisation

<table>
<thead>
<tr>
<th>System Overview (7 day working)</th>
<th>Available</th>
<th>NHS Utilised</th>
<th>Provider Utilised</th>
<th>Unused Capacity</th>
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<td>AM</td>
<td>226</td>
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<td>PM</td>
<td>226</td>
<td>145</td>
<td>10</td>
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<td>EVE</td>
<td>228</td>
<td>16</td>
<td>54</td>
<td>69.30%</td>
</tr>
<tr>
<td><strong>TOTALS including evenings &amp; weekends</strong></td>
<td><strong>680</strong></td>
<td><strong>310</strong></td>
<td><strong>74</strong></td>
<td><strong>43.53%</strong></td>
</tr>
<tr>
<td><strong>TOTALS not including weekends</strong></td>
<td><strong>506</strong></td>
<td><strong>310</strong></td>
<td><strong>74</strong></td>
<td><strong>24.11%</strong></td>
</tr>
</tbody>
</table>

Day Time Mon-Fri usage is good across the system but it does highlight opportunities elsewhere at evenings or weekends –? Staffing and specially medical cover needs resolving.

Data period:
- **Nuffield and Harbour** planned use 22/6/20-31/7/20.
- **Winterbourne** 22/06/20-03/07/20 (is there no further plan-).

Excludes unconfirmed Theatre sessions for orthopaedic work as at 23rd June - this accounts for 8 sessions. If confirmed improves (i.e. reduces) system total unused capacity.

**Caveats:**
1. Based on data as at 23/06/20 - things may have changed
2. Where there was no definitive allocation in any of the rotas capacity is assumed as unused - but IS providers may have undisclosed plans/refurb etc/non Dorset use

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**Available** - theatre session is available to be used, sessions marked as "Refurb" are not included

**NHS Utilised** - theatre session with confirmed usage by a named clinician and/or specialty

**Provider Utilised** - theatre session with confirmed usage by ISP for either private or NHS work that had been paused

**Available** - theatre session is available to be used, sessions marked as "Refurb" are not included
ED: changes between 19/20 and 20/21

**Type 1 & 2**

**Type 3**
Adverse trending LOS being addressed by Acute Discharge Group. Discharge to Assess (and wider) Identified as key priority for Recovery Group embedding beneficial gains from early Covid period.
CANCER

Referrals Received by Referral Received Week and Cancer Site

COVID Pre vs Post % change by Cancer Site

Our Dorset
Your Local NHS and Councils Working Together