Agenda

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 **31st March 2020** at **08.30am to 11.20am** in the CEO's Office and via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Emma Hallett / Dr George N Davis	Note	8.30-8.50
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	8.50-8.55
	a) Apologies for Absence: Alastair Hutchison	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated November 2020	-	Taken at Part 2 meeting January 2021	-	
	d) Matters Arising: Action Log	-	Taken at Part 2 meeting January 2021	-	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	8.55-9.05
4.	**COVID-19 Update**	Verbal	Inese Robotham	Note	9.05-9.15
5.	**Performance Scorecard and Board Sub-Committee March Escalation Reports** a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee	Enclosure	Committee Chairs and Executive Leads	Note	9.15-9.35
6.	**Health Inequalities**	Enclosure	Nick Johnson	Discuss	9.35-9.50

7.	**Recovery Framework**	Enclosure	Nick Johnson	Discuss	9.50-10.05
Coffee Break 10.05 – 10.20					
8.	**Learning from Deaths Q3 Report**	Enclosure	Julie Doherty	Discuss	10.20-10.35
9.	**Staff Survey Initial Findings**	Enclosure	Emma Hallett	Discuss	10.35-10.50
10.	• **Committee Risk Framework** • **Board Assurance Framework** • **Corporate Risk Register**	Enclosure	Trevor Hughes Nick Johnson Nicky Lucey	Approve	10.50-11.00
11.	**Workforce Race Equality Standard (WRES) Update**	Enclosure	Emma Hallett / Catherine Youers / Julie Barber	Note	11.00-11.15
	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.				
12.	**Minor and Technical Changes to Provider License Conditions Proposal**	Enclosure	Trevor Hughes	Note	
13.	**Declarations of Interest**	Enclosure	Trevor Hughes	Approve	
14.	**Committee Membership**	Enclosure	Trevor Hughes	Approve	
15.	**Delegation of Authority – Annual Report** *From Board of Directors to Risk and Audit Committee for approval of the Annual Report and Accounts at the committee meeting 18 May 2021*	Verbal	Trevor Hughes	Approve	
16.	**Any Other Business**				
	Board Meetings Future Format	Verbal	Mark Addison	Note	11.15-11.20
17.	**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 26 May 2021** via MS Teams				

Action Log – Board of Directors Part 1

Presented on: 31st March 2021

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated:						
Previous actions Incorporated into Part 2 Action Log under the interim governance arrangements implemented during the pandemic third wave.						
Actions from Committees…(Include Date)						

Title of Meeting	**Board of Directors**
Date of Meeting	**31 March 2021**
Report Title	**Chief Executive's Report**
Author	**Natalie Violet, Corporate Business Manager to the CEO**
Responsible Executive	**Patricia Miller, Chief Executive**

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

Summary
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.

The key developments nationally are as follows:

- The publication of the Department of Health and Social Care's white paper – *'Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill'.*
- The roll out of Integrated Care Systems across the country.
- The publication of the National NHS Staff Survey.
- The announcement of the spring 2021 Budget.

Local highlights include:

- Our staff thank you gesture, acknowledging their hard work and dedication over the past year.
- Our Diagnostic Imaging Department receiving the Quality Standard for Imaging (QSI) accreditation.
- Important next steps in our work on Equality, Diversity, and Inclusion.
- Further work on the review of the Trust Strategy.

Paper Previously Reviewed By
Chief Executive

Strategic Impact
For the Board to operate successfully, it must understand the wider strategic and political context.

Risk Evaluation
Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.

The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.

Impact on Care Quality Commission Registration and/or Clinical Quality An understanding of the strategic context is a key feature in strategy development and the Well Led domain. Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.	
Governance Implications (legal, clinical, equality and diversity or other): Failure to address significant strategic and operational risks could lead to regulatory action and significant deterioration in the Trust's performance against the 'Well Led' domain.	
Financial Implications Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

Chief Executives Report

Strategic Update

National Perspective

Local relevance

The Department of Health and Social Care – White Paper

On 11 February 2021 the Department of Health and Social Care (DHSC) published its white paper – *'Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill'* with the aim to create an enabling framework for local partners to build upon existing partnerships at place and system levels, and to align services and decision making in the interests of local people.

There are three factors to the government's approach:

1. The importance of shared purpose within places and systems.
2. The recognition of variation – some of it warranted – of form and in the potential balance of responsibility between places and the systems they are part of.
3. The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

The Health and Care Bill is expected to go to the House of Commons in May for discussion and debate with an engagement process in the spring. The new Health and Care Bill is expected to feature in the Queens Speech for legislation in spring 2022. NHSE/I have set up a small stakeholder group looking at governance arrangements.

Locally, Tim Goodson, Dorset ICS lead and Chief Officer of Dorset CCG, Eugine Yafele, Chief Executive of Dorset HealthCare and Matt Prosser, Chief Executive of Dorset Council has been appointed as joint Senior Responsible Officers to lead the key workstream focussing on function, governance and the operating model of the new ICS. Senior Leadership Team has identified Executive Leads and Programme Directors across system partners to take forward the other key workstreams of this transformation programme, including finance, people and culture and the framework for commissioning.

The System Partnership Board will provide oversight and scrutiny of the programme, ensuring the programme's outputs are in line with the system's strategic aims and vision. With the System Leadership Team holding the programme to account for delivery of the programme.

An ICS Development Steering Board has been created with the purpose of setting the direction for the ICS Development Programme and be accountable for the implementation and realisation of the benefits. The board will provide oversight and point of escalation for the Programme Delivery Group and provides assurance to the Senior Leadership Team & System Partnership Board. Membership consists of the Exec Leads from each workstream.

The local ambition is to:

1. Develop a strong and effective integrated care system in Dorset by building on the NHS Long Term Plans vision of health and care joined up locally around people's needs and removing the legislative barriers to integration across health and care.
2. Support the development of the ICS in line with proposed legislative changes that are scheduled to come into effect from April 2022.

3. Initiate and develop work-streams to prepare the ICS for the transformation of the health system over the coming year in line with recent proposed legislative changes.
4. Design a Transformation function that supports the required workstreams to achieve their objectives during 2021/22.

Integrated Care Systems (ICS) Roll Out

On 19 March 2021 Sir Simon Stevens confirmed the final 13 areas in the country will be formally designated as ICSs from 01 April 2021, creating 42 further ICSs in England. This is a major milestone in the NHS Long Term Plan achieving the aim to create ICSs across the nation. The Health Secretary suggested earlier this month the CQC will have a role in regulating ICSs moving forward.

Recovery

February saw the announcement of the Governments 'roadmap out of lockdown'. Staff wellbeing remains our priority. We have concentrated on offering and developing several wellbeing initiatives since the start of the first wave of the pandemic as we recognise the emotional and psychological impact the pandemic has had upon our staff. There are early indications from NHS England the full restart of services will not commence until the second quarter of 2021/22. We are therefore looking to create time and space during the first quarter for staff recovery and are working with our senior leaders within the organisation to establish the best way to do this. Nick Johnson is the Executive lead for this work.

In terms of the recovery of services, the number of people waiting for hospital treatment has risen to a new record high and organisations must be realistic regarding capacity to tackle backlogs and manage expectations. It is expected the maximum waiting time organisations will be measured against will be two years from date of referral. Although the operating framework is yet to be published. NHS England's Board Meeting, at the end of this month, is expected to sign off the framework which is expected to cover the first six months of next year.

National CEO Advisory Group – Elective Recovery

Following nomination from Elizabeth O'Mahony, I am participating in a national Chief Executive advisory group looking at elective recovery. This is in an independent advisory role rather than representing the system. It is an opportunity to provide insight and advice to the national team shaping the recovery agenda.

HSJ Top Chief Executives 2021

It was a pleasure to be included in the HSJ's top 50 chief executives this year, I was really pleased to see four of the eight hospital CEOs from ethnic minority communities included. This is a step in the right direction for inclusion in the NHS.

National NHS Staff Survey

We saw the publication of the National NHS Staff Survey results this month, providing important insight into working in NHS Trusts throughout the country and the results are used to review and improve working lives for staff.

The latest results cover 2020, the pandemic has meant the year has been far from 'business as usual' for the NHS workforce. However, the NHS Staff Survey has measured staff experience in a consistent way to previous years with the same methodology, timings and questions to maintain comparability of the data and allow NHS organisations to compare question responses and theme scores to life before COVID-19.

The organisation completion rate was 46% and scored above or the same as the national average for all 10 key themes in the 2020 results – equality, diversity and inclusion; health and wellbeing; immediate managers; morale; quality of care; safe environment; violence; safety culture; staff engagement and team working.

The organisation's overall score for the theme of equality, diversity and inclusion was lower than 2019. However, this represents our active encouragement of staff to use their voice to speak up about their experiences of discrimination in the workplace and if you correlate this with being rated as a good employer our important next steps are to take the necessary action.

Spring Budget 2021

Earlier this month the government published its spring 2021 Budget.

Key headlines include:

- An extra £1.65 billion for the COVID-19 vaccination programme.
- An extension, into summer, of the Test and Trace one off payments of £500 to protect incomes for those isolating.
- Continued suspension of tariffs on medical products used to tackle COVID-19.
- The pensions lifetime allowance to be frozen until April 2026 which may result in further workforce constraints due to staff retiring earlier.
- NHS England's overall budget for 2021/22 will be reduced is plans reduce pandemic spending. Following negotiation between NHS England and the Treasury an additional £6.6 billion has now been agreed to cover COVID expenditure for the first six months of 2021/22.
- An additional £10 million for mental health support of veterans.
- An unsponsored, points-based visa to attract highly skilled migrants in academia, science, research, and technology.
- An increase of apprenticeship incentive payments to £3,000 for new apprentices for the first six months of 2021/22.

Following the Budget announcement, the Department of Health and Social Care submitted to the NHS Pay Review Body suggesting a 1% pay rise for agenda for change staff. This differed from the 2.1% NHS pay rise assumed in the 2019 Long Term Plan. The government has experienced a media backlash following the submission with NHS Providers challenging the government's decision being based on affordability.

Change in Immigration Rules

The rules regarding immigration were amended this month to include senior care workers, nursing assistants and pharmacists on the occupations with labour shortages list with the aim to reduce vacancies within the NHS.

Locally, we are stepping up our overseas recruitment campaign to support our elective restart. We are making plans for the next round of recruitment of 40 overseas nurses to join the Trust from next month onwards.

National Day of Reflection

A national day of reflection, marking one year since the beginning of the first lock down, took place this month providing an opportunity to remember those who lost their lives to COVID-19 and pay tribute to the public's sacrifice to protect the NHS.

DCH Performance

Performance

The Trust continues to operate with reduced capacity, although COVID demand has reduced we are still experiencing an impact of the Verne prison outbreak. Our Emergency Department attendances remain below last years activity however have seen an increase in patient acuity. Pleasingly the department is second in the region for ambulance handover delays. The organisation remains challenged with delayed discharges.

The elective waiting list has remained static over the last four months however the impact of the pandemic has significantly changed the profile increasing the number of patients waiting beyond 52 weeks. Our Diagnostic performance has improved month of month for the last six months with significant improvement in endoscopy and ultrasound.

Cancer performance for two-week waits has improved however there is further work required to address the backlog in breast, despite mutual aid assistance from UHD breast referrals continue to rise. 62-day performance remains static with a reduction in patients waiting beyond 62 days, we are expecting to see improved performance in the coming months.

In terms of performance our focus over the next twelve months needs to move to elective recovery. The NHS Planning Framework which is expected on 25th March 2021, will outline expectations in terms of priorities and recovery trajectories and the funding envelope that will be available to support these.

Radiology Accreditation

We received some fantastic news this month, our Diagnostic Imaging Department received national recognition, following three years of hard work and dedication, the department has been granted the Quality Standard for Imaging (QSI) accreditation. This is recognition of the department's dedication to provide a safe and efficient service for our patients.

Equality, Diversity, and Inclusion

The next steps in our Equality, Diversity and Inclusion agenda are underway. The development of the Equality, Diversity and Inclusion Strategy is almost complete and will be brought to the People and Culture Committee and Board in April for agreement. Key work programmes contained with it are as follows:

- The Executive Team are working with members of our Diversity Network to review a selection of our policies and procedures relating to recruitment, appraisal and succession planning and staff conduct and disciplinary matters.

- We are developing our Pro Equity Leadership Development Programme with plans to commence four initial cohorts in early June. Each cohort will comprise of 20 staff members and will be compulsory for staff at Band 7 and above with line management responsibility. We are looking to commence reciprocal mentoring alongside the first cohorts, and this will involve 20 staff from the first four cohorts of the Pro Equity Programme.

- Julie Barber, Head Organisational Development is working towards developing a leadership development offer for staff Band 6 and below which will focus on behaviours through the lens of dignity and respect.

LGBTQ+ and Disability Networks

We are in the process of creating our LGBTQ+ Network with a staff member volunteering to be the Chair. Inese Robotham will be the Executive sponsor for this Network.

A member of staff has also stepped forward to chair the Disability Network. We will now identify and Executive sponsor. All networks will then develop formal terms of reference with an agreed reporting line into the Equality, Diversity and Inclusion Steering Group which in turn reports into the People and Culture Committee. This will provide clear line of sight for the networks into corporate decision making.

Trust Strategy

Work continues in reviewing our current Trust Strategy with stakeholder engagement events taking place. We are currently in the design phase and are looking to develop delivery plans against the updated strategic goals.

Vaccination

Our hospital vaccine hub has now reopened to commence the administering of second dose vaccines. Our staff vaccination figures are promising with 93% of substantive frontline staff and 74% of all staff having received their first vaccine. 68% of all ethnic minority staff have received their first vaccine. We have a group of eight vaccine champions who will be having 1:1 conversations with staff who have chosen not to have the vaccination.

Staff Thank You

The Chairman and I arranged for all staff to receive a letter and gift to acknowledge their hard work and dedication over the past year. The last 12 months have been a significant challenge for many, not just due to the impact the pandemic has had on the hospital but also the emotional fall out from being unable to see loved ones for such a protracted period of time. All staff have been amazing during this period. Going beyond the extra mile, showing great humility and courage often putting themselves in harm's way in order to care for the most vulnerable. Their response has made me incredibly proud. The gift, a token of appreciation from the Board, includes a £25 Love2Shop voucher and free Costa coffee. Distribution is currently underway and the initial feedback from the staff has been very positive.

Patricia Miller, Chief Executive
31st March 2021

Meeting Title:	**Board of Directors**
Date of Meeting:	**31 March 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)	23 March 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 February 2021: The Trust did meet the standard for: • The total waiting list size • All Cancers - 31 Day Subsequent Treatment (Radiotherapy/Other) • All Cancers - 31 Day Subsequent Treatment (Anti-Cancer Drugs) • All Cancers - 31 Day Subsequent Treatment (Surgery) The Trust did not meet the standards for: • Zero 52 week waits • Zero 104 week waits • RTT • 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 Diagnosis to First Treatment Cancer performance for February 2021 will not be confirmed for a further 6 weeks as the shared breaches with external partners will be applied and agreed by NHSE. Looking forward to March 2021, it is anticipated that DCH will: Meet the following standards: • Waiting list size • Cancer 31 days (all)							

	DCH will not meet the standard in March 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 • Zero 52 week waits • Zero 104 week waits **Escalation Reports** The March Board sub-committees met as follows: Monday 22 March: People and Culture Committee Tuesday 23 March: Quality Committee, Finance and Performance Committee, Risk and Audit Committee. 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: 1. **NOTE** the performance data 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

Integrated Performance Report
Board of Directors Meeting 31 March 2021

Metric	Threshold/ Standard	Type of Standard	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Q1	Q2	Q3	Q4	YTD	Movement on Previous Period	12 Month Trend
Safe															
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	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	**3 (0.5)**	0 (0.0)	3 (0.4)	2 (0.3)	1 (0.1)	2 (0.3)	1 (0.1)	**6 (0.3)**	5 (0.2)	3 (0.2)	**15 (0.2)**	↓	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	3	2	0	0	0	2	1	5	2	2	10	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	5	10	15	5	7	6	25	25	30	13	93	**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	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	0	0	0	**4**	**2**	**2**	5	3	4	2	14	↔	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	**1 (0.1)**	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.1)	2 (0.1)	↑	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	2 (0.2)	2 (0.2)	3 (0.4)	0 (0.0)	0 (0.0)	1 (0.2)	3 (0.2)	4 (0.2)	5 (0.1)	1 (0.0)	12 (0.1)	↓	
Emergency caesarean section rate			20.9%	16.4%	27.5%	20.5%	19.5%	20.9%	15.7%	21.3%	21.2%	20.2%	19.6%	↓	
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)	94.0%	**88.9%**	90.0%	100%	100%	96.0%	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	91.0%	97.0%	90.0%	96.0%	**81.0%**	96.0%	N/A	N/A	N/A	N/A	N/A	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**74.0%**	**68.0%**	91.3%	**75.0%**	**77.3%**	**57.9%**	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**87.0%**	93.0%	96.3%	96.0%	**85.0%**	**84.0%**	N/A	N/A	N/A	N/A	N/A	↓	
Effective															
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	2	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.14 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	1.11	1.10	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**113.9**	**109.8**	**108.3**	**109.6**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**110.7**	**105.6**	**104.0**	**102.5**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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)	**16.0%**	**49.8%**	**42.0%**	**57.7%**	**65.9%**	**70.5%**	**33.1%**	**18.0%**	**50.1%**	**68.0%**	**39.6%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	**89.5%**	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	99.2%	↔	
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)	100.0%	**86.1%**	**73.3%**	**83.3%**	**75.0%**	**88.0%**	**62.2%**	**68.0%**	**82.7%**	**81.1%**	**76.3%**	↑	
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	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	23	27	34	33	31	22	41	82	94	53	270	↑	
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%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**92.9%**	**94.2%**	**94.9%**	**89.1%**	96.9%	**94.6%**	99.4%	**94.8%**	**92.8%**	**95.8%**	**94.4%**	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	86.2%	89.1%	89.9%	87.8%	95.7%	89.7%	91.8%	89.3%	88.9%	92.8%	90.3%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	92.4%	**93.1%**	95.2%	**93.6%**	94.8%	**93.3%**	**91.6%**	**92.4%**	94.0%	94.1%	**93.1%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**6**	**5**	**9**	**6**	N/A	N/A	**24**	**15**	**20**	**0**	**59**	↓	

Metric	Threshold/ Standard	Type of Standard	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Q1	Q2	Q3	Q4	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)	**46.7%**	**49.4%**	**52.1%**	**53.3%**	**51.3%**	**50.5%**	**40.4%**	**46.7%**	**51.3%**	**50.9%**	**47.4%**	↓	
RTT Incomplete Pathway Waiting List size	**19,396**		15,439	15,659	16,038	16,251	16,110	16,162	14,182	15,439	16,251	161,162	16,162	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**54.5%**	**57.2%**	**65.4%**	**73.1%**	**61.7%**	**75.3%**	**86.4%**	**62.1%**	**64.8%**	**68.8%**	**69.1%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**13.6%**	**14.3%**	**9.1%**	**0.0%**	**21.4%**	**28.6%**	95.9%	**35.1%**	**9.5%**	**27.4%**	**42.7%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	99.0%	98.7%	98.2%	97.9%	97.9%	**93.6%**	**95.8%**	98.2%	98.2%	**95.6%**	97.1%	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	**71.4%**	100.0%	94.4%	100.0%	100.0%	**80.0%**	95.2%	↑	
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%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	100.0%	-	-	-	-	100.0%	100.0%	100.0%	-	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**68.5%**	**73.0%**	**76.1%**	**71.4%**	**75.7%**	**66.0%**	**70.2%**	**70.5%**	**73.6%**	**70.7%**	**70.2%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**0.0%**	**57.1%**	**33.3%**	100.0%	**76.9%**	**83.3%**	**70.0%**	**0.0%**	**69.0%**	**80.0%**	**70.0%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**60.7%**	**66.1%**	**72.8%**	**73.6%**	**75.9%**	**82.5%**	**47.7%**	**59.7%**	**70.9%**	**79.0%**	**63.4%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**87.0%**	**86.2%**	**90.6%**	**84.2%**	**78.8%**	**79.2%**	**92.3%**	**91.0%**	**86.9%**	**79.0%**	**88.3%**	↑	
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)	**92.7%**	**91.8%**	**94.1%**	**90.2%**	**87.3%**	**88.6%**	95.2%	95.1%	**92.0%**	**87.9%**	**93.1%**	↑	
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		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**3.33%**	**3.55%**	**3.50%**	**3.29%**	**4.89%**	N/A	**3.69%**	**3.41%**	**3.43%**	**4.89%**	**3.7%**	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**73%**	**74%**	**76%**	**77%**	**76%**	**76%**	**76%**	**73%**	**76%**	**76%**	**75%**	↔	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.9%	8.85%	8.6%	8.4%	8.23%	7.7%	9.3%	8.8%	8.59%	8.0%	8.7%	↑	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,603.5	2,599.7	2,663.5	2630.9	2,644.2	2,720.6	2,630.9	2,624.2	2,631.6	2,682.4	2,630.4	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**6.9%**	**7.2%**	**6.4%**	**6.4%**	**6.4%**	**5.7%**	**6.4%**	**7.0%**	**7.2%**	**6.1%**	**6.7%**	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**11,057.1**	**10,338.4**	**10,628.8**	**10,415.30**	**10,703.0**	**10,978.2**	**10,611.3**	**10,565.0**	**10,483.6**	**10,840.6**	**10,561.5**	↑	
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	0	↔	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**87%**	**87%**	**88%**	**87%**	**87%**	**87%**	**87%**	**87%**	**87%**	**87%**	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,080**	**2,135**	**2,212**	**2,149**	**1,904**	**1,865**	**2,739**	**4,967**	**6,496**	**3,769**	**17,971**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£1,712,745**	**£1,985,193**	**£2,108,875**	**£1,996,334**	**£1,473,699**	**£1,443,882**	**£2,643,794**	**£4,417,359**	**£6,090,402**	**£2,917,581**	**£16,069,136**	↓	
Surplus/(deficit) (year to date)	**2020/21 = (11,677) YTD M11 = (9,690)**	Local Plan	0	(999)	(891)	(1,901)	(2,055)	(805)	0	0	(1,901)	(805)	(805)	**N/A**	**N/A**
Cash Balance	**2020/21 - 1,236 M11 = 15,066**		22,595	24,590	24,589	24,134	25,648	29,286	21,657	22,595	24,134	25,648	29,286	↑	
CIP - year to date (aggressive cost reduction plans)	**2020/21 = 529 YTD M11 = 441**	Local Plan	N/A	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	N/A	N/A	Yet to be decided	Yet to be decided	Yet to be decided	**N/A**	**N/A**
Agency spend YTD	**2020/21 = No Annual value YTD M11 = 9,716**		**4,439**	**5,458**	6,358	7,199	8,117	8,985	**2,009**	**4,439**	7,199	8,985	8,985	**N/A**	**N/A**
Agency % of pay expenditure	**2020/21 = No Annual value YTD M11 = 7.1%**		**6.1%**	**6.4%**	**6.6%**	6.6%	6.7%	6.7%	5.6%	**6.1%**	6.6%	6.7%	6.7%	↔	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Rating Key

	Achieving Standard
	Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Jan-21	Feb-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 (0.3)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	1 (0.1)	**2 (0.3)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	0	2
	SHMI - Rolling 12 months, 4 months in arrears (Oct-19 to Sep-20)	**<1.14**	1.10	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Nov-19 to Oct-20)	**100**	**109.6**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**51.3%**	**50.5%**
	RTT Incomplete Pathway Waiting List size	**19,396**	16,110	16,162
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**75.7%**	**66.0%**
	Maximum 6 week wait for diagnostic tests	**99%**	**75.9%**	**82.5%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**87.3%**	**88.6%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**1,473,699**	**1,443,882**
	Surplus/(deficit) (year to date)	**2020/21 = (11,677) YTD M11 = (9,690)**	(2,055)	(805)
	CIP - year to date (aggressive cost reduction plans)	**2020/21 = 529 YTD M11 = 441**	Yet to be decided	Yet to be decided
	Agency spend YTD	**2020/21 = No Annual value YTD M11 = 9,716**	8,117	8,985

Rating Key

Escalation Report

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

Date of Meeting: 22nd March 2021

Presented by: Judy Gillow

Significant risks / issues for escalation to Board for action	The Committee discussed the findings contained within the following reports at length, noting interdependencies and further actions: • Agency Deep Dive and Expenditure Review highlighting the complex issues which affect demand. • Health and Wellbeing Annual Report and developing staff support plans day to day, in the short and medium term. • National Staff Survey findings and WRES update noting the need to better understand staff experiences and review the findings at a granular level
Key issues / other matters discussed by the Committee	The committee also received, discussed and noted the following reports: • Workforce Performance and COVID Update Report requesting further information of the impact of Bank and Agency fill rates of Safest Staffing arrangements and a future focussed discussion on appraisals. • A review of vaccine uptake within the trust – further information and report requested on the variation between staff groups. • Education Bi-monthly Report noting the maintenance of educational activity during the pandemic
Decisions made by the Committee	• Quarterly Agency Expenditure reports to be presented to the committee going forward • Staff Survey and WRES action plan approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None
Items / issues for referral to other Committees	• Additional NHSI funding to support international recruitment

Escalation Report

Committee: Quality Committee

Date of Meeting: 23rd March 2021

Presented by: Judy Gillow/Nicky Lucey

Significant risks / issues for escalation to Committee / Board for action	• The committee were informed of a national change to wider reviews of 'all cause deterioration' of which sepsis was one component • The committee noted national and regional discussions focusing on outcomes based performance metrics and assurances with further guidance expected in Quarter 1 along with guidance on the developing system wide oversight framework.
Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports: • Health Inequalities Update • Quality and Safety Performance Report – An update of stroke data to be provided • Maternity Quality and Safety Dashboard Exceptions, noting funding to support reaccreditation of baby friendly services, maintenance of breastfeeding and work within the region to develop a maternity dashboard that work enable service benchmarking. • Ockenden Action Plan Update and service risk alignment • No sub-committee Minutes and Escalation Reports were received
Decisions made by the Committee	• The approach proposed to addressing Health Inequalities was supported and included the establishment of a DCH Health Inequalities Group and commitment of resources
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Whilst the Ockenden Action Plan is robust, further work is required in order to align wider service risks.
Items / issues for referral to other Committees	• Review of the Performance Dashboard by the Executive team to ensure a consistent approach, inform committee priorities going forward and consideration of the system-wide oversight framework as guidance emerges.

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 23rd March 2021

Presented by: Stephen Tilton

Significant risks / issues for escalation to Board for action	• The year-end financial forecast is to achieve a break-even position.
Key issues / other matters discussed by the Committee	• Finance and Performance updates including COVID update and financial forecast. • Outline Recovery Framework • ED 15 Project Update • DCH Subco Quarter 3 Report • Health Trust Europe (HTE), Total Workforce Solutions (TWS) Framework • No Escalation Reports were received.
Decisions made by the Committee	The following items were approved by the committee and are recommended to the Board: • Critical Care Senior Resident Proposal • Q1 2021/22 Budget Proposal • Capital Plan proposal 2021/22 • Orthopaedic Primary Hip and Knees Business Case
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Continued uncertainty in relation to the funding arrangements nationally in the latter part of 2021/22
Items / issues for referral to other Committees	• Further consideration and review of risks for unfunded capital programmes to be undertaken by Risk and Audit Committee in June

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 23rd March 2021

Presented by: Ian Metcalfe

Significant risks / issues for escalation to Board for action	• Proposal of how risks are managed in and escalated from Board Committees; • Addition of statement within the Risk Management Framework of 'managed within risk appetite'; • Going Concern Statement; • Underlying deficit position of the Trust and System.
Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Counter Fraud Update • Corporate Risk Register • COVID Risk Reduction Report • PCC Workforce Risk Report • Board Assurance Framework Update • Register of Interests • Register of Gifts and Hospitality noting the need to promote clarity amongst staff about what should be declared • Creditor payment performance requires improvement
Decisions made by the Committee	• The committee approved the following: • Revised Internal Audit Plan 2021/22 • External Audit Progress Report • Counter Fraud Work Plan 2021/22 • Charitable Funds Consolidation • Review of Accounting Policies Area of Estimation
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Review of the Board Assurance Framework and alignment to the refreshed strategy was noted.
Items / issues for referral to other Committees	•

Meeting Title:	Board
Date of Meeting:	31st March
Document Title:	**Health Inequalities**
Responsible Director:	Nick Johnson – Deputy CEO
Author:	Nick Johnson – Deputy CEO

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Health Inequalities Group	22nd March	Discussion on App 2 at Feb HI Group
SMT		
Quality Committee	23rd March	Aim to be reviewed, community engagement imperative

Purpose of the Paper	For approval
Summary of Key Issues	Addressing Health Inequalities - avoidable, unfair and systematic differences in health between different groups of people - is part of the NHS response to COVID-19 recovery and is central to the wider NHS Long Term Plan. This report provides an update to Board on the emerging Dorset ICS approach and sets out the HI Approach for DCH for approval.
Action recommended	The Board are asked to 1. Note the update and provide comment 2. Approve the DCH Health Inequalities Approach in Appendix 3 3. Support the establishment of the DCH Health Inequalities Group and the commitment of resources to the programme

Governance and Compliance Obligations

Legal / Regulatory	Yes	Equality Act, Social Value Act compliance
Financial	Yes	Commitment of resources, opportunity to reduce costs
Impacts Strategic Objectives?	Yes	Contribution to the Place agenda
Risk?	Yes	
Decision to be made?	Yes	As per recommendations
Impacts CQC Standards?	No	No
Impacts Social Value ambitions?	Yes	SV a key theme within the wider HI agenda
Equality Impact Assessment?	Yes	Attached
Quality Impact Assessment?	No	Not directly as a result of this report.

1. INTRODUCTION

1.1 In September 2020 a report was presented to Trust Board signalling the commencement of work to more systemically address health inequalities. This report provides an update on the Trust's proposed approach to addressing Health Inequalities across our population and working towards greater equity in health outcomes.

1.2 The approach described within this report and set out in the attached appendices does not provide detailed solutions, rather it seeks to provide a foundation for better addressing health inequalities. This Health Inequalities programme across Dorset and at Dorset County Hospital will be dynamic and iterative as our understanding of the issue and the effectiveness of our responses develop.

2. BACKGROUND AND CONTEXT

2.1 COVID-19 has shone harsh light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. COVID-19 will further compounding inequalities which had already been widening.

2.2 The impact of Health Inequalities prior to and during the Covid pandemic were evident and demonstrated in numerous studies[1][2]

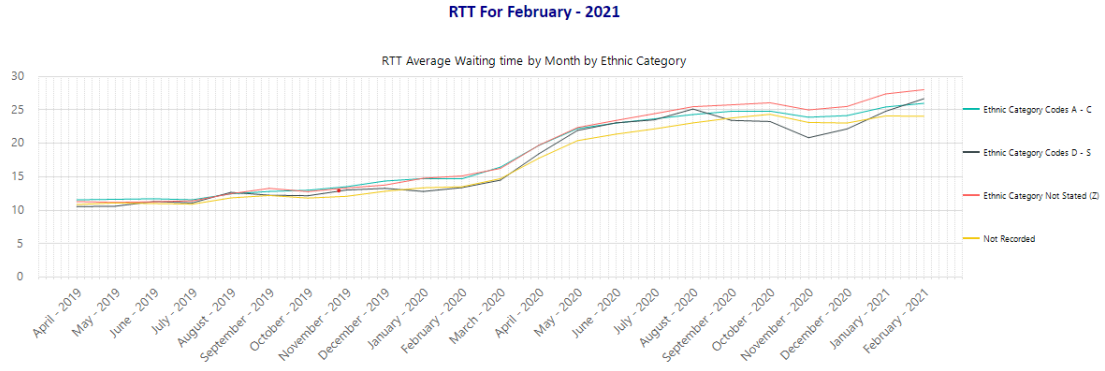
2.3 Addressing Health Inequalities is part of the NHS response to COVID-19 recovery and is central to the wider NHS Long Term Plan. Measures set out by the NHS in July 2020 were designed to help lay the foundations for further action, particularly to enhance prevention and contribute to the concerted cross-governmental and societal effort needed to address the wider determinants of health; building on the strategy set out in the NHS Long Term Plan and the NHS's legal duties with regards to equality and health inequalities

2.4 At a national level the NHS has sought to take action, building on its commitment within the 2019 Long Term Plan, through the Covid pandemic. A number of recommendations were produced in July 2020 and subsequently a national Health Inequalities lead has been identified, whilst health inequalities has been made a central theme in the recovery of NHS services.

2.5 DCH Impact - At DCH the health inequalities impact of Covid on access to services has been considered and monitored. For example, a dashboard looking at the RTT and Diagnostic waiting times for different ethnicity groups has been developed which does not indicate any statistically significant variation in waiting time. This of course only accounts for those who have accessed or been referred to DCH services.

[1] https://www.nuffieldtrust.org.uk/news-item/poorest-get-worse-quality-of-nhs-care-in-england-new-research-finds

[2] https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-health-inequalities-and-covid-19-may-2020#:~:text=The%20unequal%20risk%20of%20becoming%20seriously%20ill%20from%20COVID%2D19&text=The%20greatest%20risk%20factor%20for,and%20in%20certain%20occupational%20groups.



2.5.1 Additionally, the impact on access to DCH Emergency Department has been considered. Overall unplanned attendances to DCH ED:

- fell by 34.2% (-4186) during the lockdown 1 (23rd March to 19th June), equating to a reduction of 47 attendances per day
- fell by 13.6% (-597) during lockdown 2 (31st October to 2nd December), equating to a reduction of 18 attendances per day
- fell by 26.4% (-1219) during lockdown 3 to date (5th January to 9th February), equating to a reduction of 34 attendances per day
- Minority ethnic groups (D-S) reduced by 36.4% during lockdown 1, 9.5% in lockdown 2 and 25.5% in lockdown 3 so far, however this only equates to a drop of 52, 4 and 12 attendances respectively, with any lower level analysis into specific ethnicities relating to small numbers. White ethnic groups (A-C) reduced by 25.4% (-2218) in lockdown 1, 9.0% (-292) in lockdown 2 and 27.3% (-957) in lockdown 3 to date.
- attendances for those aged under 20yrs saw the largest decrease during lockdown 1, lockdown 2 (along with those aged 30-39) and lockdown 3 so far.
- There were no notable variances between males and females during all lockdown period

3. KEY ISSUES AND ACTIONS

3.1 NHS 'Phase 3' (July 2020) Recommendations - In July 2020 NHSEI made 8 recommendations for providers to consider. A summary of DCH's position against each of these recommendations is attached at Appendix A. These have proved a useful catalyst for taking this agenda forward, however, they do not drive the ongoing strategy and plan.

3.2 ICS work and approach – The Dorset System Partnership Board agreed that reducing Health Inequalities is the top system priority. A position statement has been created, a CEO SRO (Patricia Miller, CEO DCH) has been appointed, a cross-system HI Group, including LAs, Police and Fire, has been established and programme resource allocated. The programme is now in the process of planning community engagement to build a strategy and approach based on the views of the local populations and their needs.

3.3 Health Foundation Bid – The Dorset ICS, with DCH Deputy CEO as Exec Lead, submitted a bid for the Health Foundations Economies for Healthier Lives; a £1.72m funding round to support partnerships to promote health and reduce health inequalities through economic development strategies. The programme will support 3-4 partnerships over 3-4 years with between £300-£500k

3.4 NHS Charities Together – Phase 3 allocation of NHS Charities Together funding is focussed on supporting local communities. Approximately £360k has been allocated to Dorset. DCH Charity is leading the coordination of this for Dorset NHS Charities and through the ICS HI Group it has been agreed that the main focus for projects and initiatives will be on reducing Health Inequalities in our communities.

3.5 **DCH Strategy and Approach –** The DCH Strategy and Approach (Appendix 3) has been designed to be dynamic and iterative to reflect the emerging HI agenda at a national and system level. In particular the DCH approach will need to complement the ICS HI strategy and approach which is still being formulated.

3.5.1 Broadly, the ICS HI Group will focus on system and place-based approaches to addressing health inequalities whilst the DCH approach will focus on changing culture and practice within DCH.

3.5.2 Community engagement and consultation on the HI agenda will be lead at the System Programme level to minimise duplication of engagement and minimise consultation fatigue amongst communities. The ICS is also better placed, with a better infrastructure to lead the community engagement. DCH will be fully involved in any engagement.

3.5.3 At DCH there will be a particular focus on:

- Minimising detrimental impact on health of race, deprivation (particularly rural), physical and mental disabilities, and LGBTQ+
- Reducing the inequalities /symptoms of which drives most demand for DCH services
- early years and childhood and transition services

3.5.4 The aim for the DCH HI Strategy is

- ***"To ensure that we take every opportunity at DCH to ensure equity of access and outcomes for all our communities"***

3.5.5 The key objectives of the DCH HI Strategy are to:

- Recognise, support and enhance existing DCH work
- Ensure we have the right data, reporting and insights to inform all our decision-making and ensure HIR are considered in all we do
- Educate and inform all our staff about the impact of Health Inequalities with a particular focus on health literacy
- Ensure health inequality reductions (HIR) are considered as part of our Quality Improvements
- Embedding prevention and health inequalities reductions (HIR) approaches within our day to day business, operational processes, digital process and clinical pathways (e.g. MECC)
- Use our position as an Anchor Institution to enhance our social value contribution
- To support staff who may experience health inequalities directly or indirectly

3.5.6 The DCH Strategy was developed following engagement with key stakeholders across the Trust and through feedback at a number of open virtual staff sessions. The DCH HI Strategy has also been signed-off by the DCH HI Group and SMT. At this stage, given the planned ICS engagement, patients and local communities have not been directly engaged with.

3.5.7 This is a significant, strategically important programme which is still being established and developed and it is therefore in need of a dedicated programme and resource. A DCH HI Group has been established and is chaired by the Deputy CEO and Board lead for Health Inequalities.

3.5.8 The DCH Transformation and Improvement Team will provide resource to create a fixed-term HI Programme Officer role. This will be topped up by some charitable funding. Additionally, the appointment of a HI Clinical Lead will be made on a fixed-term basis, again with charitable funding. This approach enables the programme to establish a clear action plan and create a longer-term, sustainable funding model.

4. RECOMMENDATION

4.1 It is recommended that Board

- Note the update
- Approve the DCH Health Inequalities Approach in Appendix 2
- Support the establishment of the DCH Health Inequalities Group and the commitment of resources to the programme

Appendix 1 – Status against NHSEI '8 Recommendations'

Recommendation	**Position/Update**
Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.	Data dashboard and Pop Health Management. Dorset ICS Group with focus on community engagement to inform strategy and approach. DCH Social Value approach targeting most deprived and affected communities.
Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.	Data monitoring looking at waiting times for different ethnic groups. Monitoring of UEC attendances
Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March	Building requirement into digital O/P processes PALS complaints indicate patient dissatisfaction. Learning fed into O/P work. Primary care/CCG to consider how patients at point of referral. Rapid learning work through AHSN on take-up of digitial services during covid to learn lessons
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.	Covid and flu monitoring by ethnicity. Development at DCH of long-term condition programme supported by Population Health Management. Implementation of maternity package to support those from ethnic minority communities patients through a QI project. We have, over the last few years had many projects to reduce barriers and health inequalities for people with a learning disability and or autism. There are the NHSI Learning Disability Standards for NHS Trusts (We report on these via the Safeguarding Group) as well as LeDeR (Learning Disability Mortality review.
Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.	Dorset HealthCare lead on MH. At DCH the DIIS data will enable identification of those patients with MH issues and we will continue to seek to share data appropriately.

	DCH continue to provide well-being and counselling services for our staff.
Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.	DCH Deputy CEO is the named Board executive. The DCH People Plan and EDI Strategy, along with proactive work on inclusive processes and policies all seek to increase the diversity of senior leadership
Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.	DCH collects approximately 80-85% patient ethnicity data. DCH HIG is developing plans to collect more data on patient ethnicity and monitor via a dashboard. The transfer of the DIIS to DCH will enable monitoring of patient data by LSOA, and other elements. Further plans will be implemented to maximise coverage.
8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.	The Dorset ICS has identified Health Inequalities as a top priority. A Programme has been formed, with a CEO SRO, programme resources and a System HI Group meeting with LA representatives. Community engagement sessions planned in March and April. This report and appendices provide the required update by 31st March for DCH.

Appendix 2

Dorset County Hospital NHS Foundation Trust

EQUALITY IMPACT AND COMPLIANCE ASSESSMENT

1. General	
Title of document	Health Inequalities Strategy
Purpose of document	To set out Trust approach to reducing health inequalities
Intended scope	All DCH

2. Consultation	
Which groups/associations/bodies or individuals were consulted in the formulation of this document?	Key stakeholders across the Trust. No formal groups.
What was the impact of any feedback on the document?	
Who was involved in the approval of the final document?	SMT, QC, Board
Any other comments to record?	

3. Equality Impact Assessment	
Does the document unfairly affect certain staff or groups of staff? If so, please state how this is justified.	No. It is intended to minimise impact on groups
What measures are proposed to address any inequity?	N/A
Can the document be made available in alternative format or in translation?	

4. Compliance Assessment	
Does the document comply with relevant employment legislation? **Please specify.**	Yes.

5. Document assessed by:	
Name	
Post Title/ Position	
Date	

Reducing Health Inequalities @DCH

Outstanding care for people in ways which matter to them

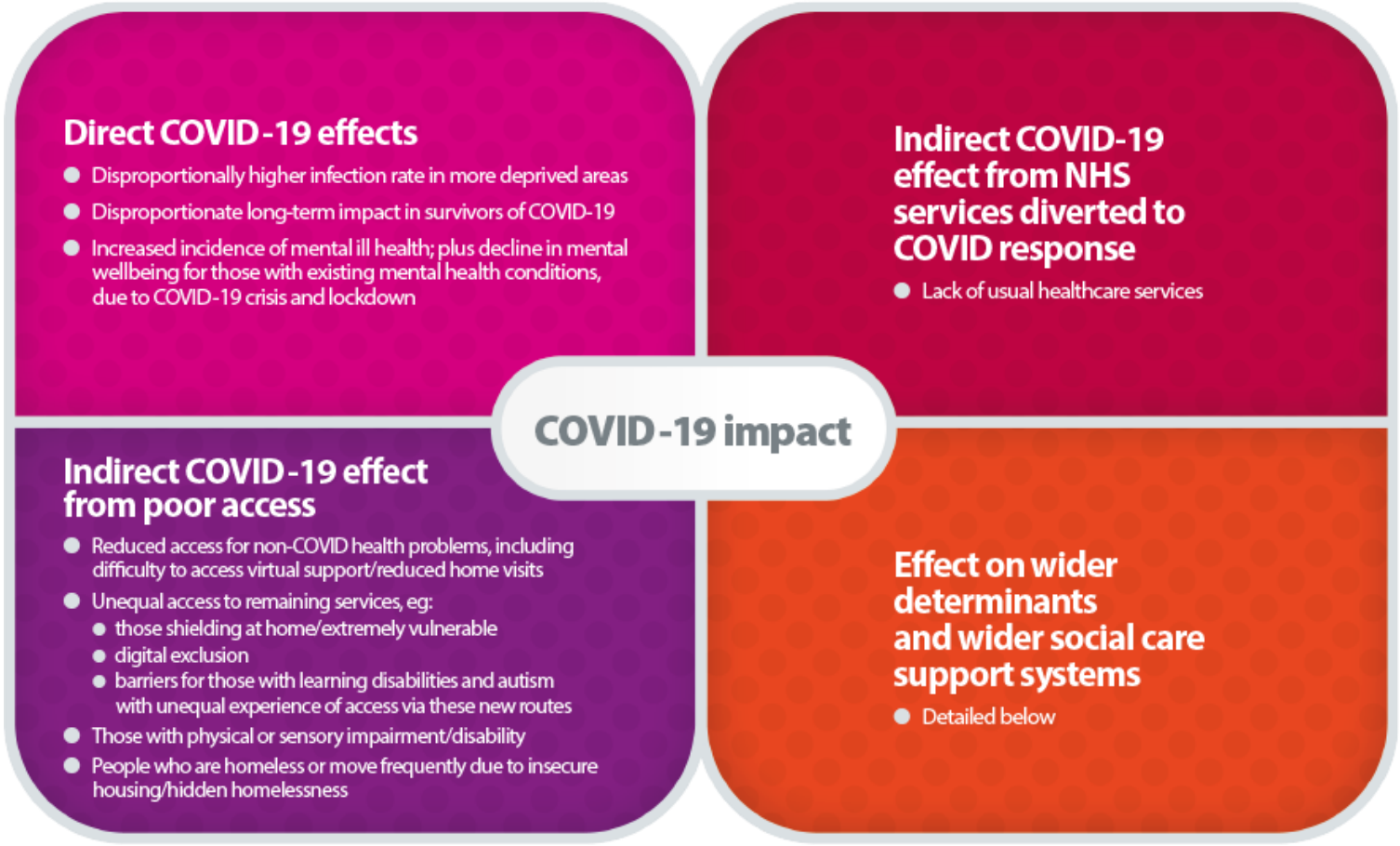
Health Inequalities

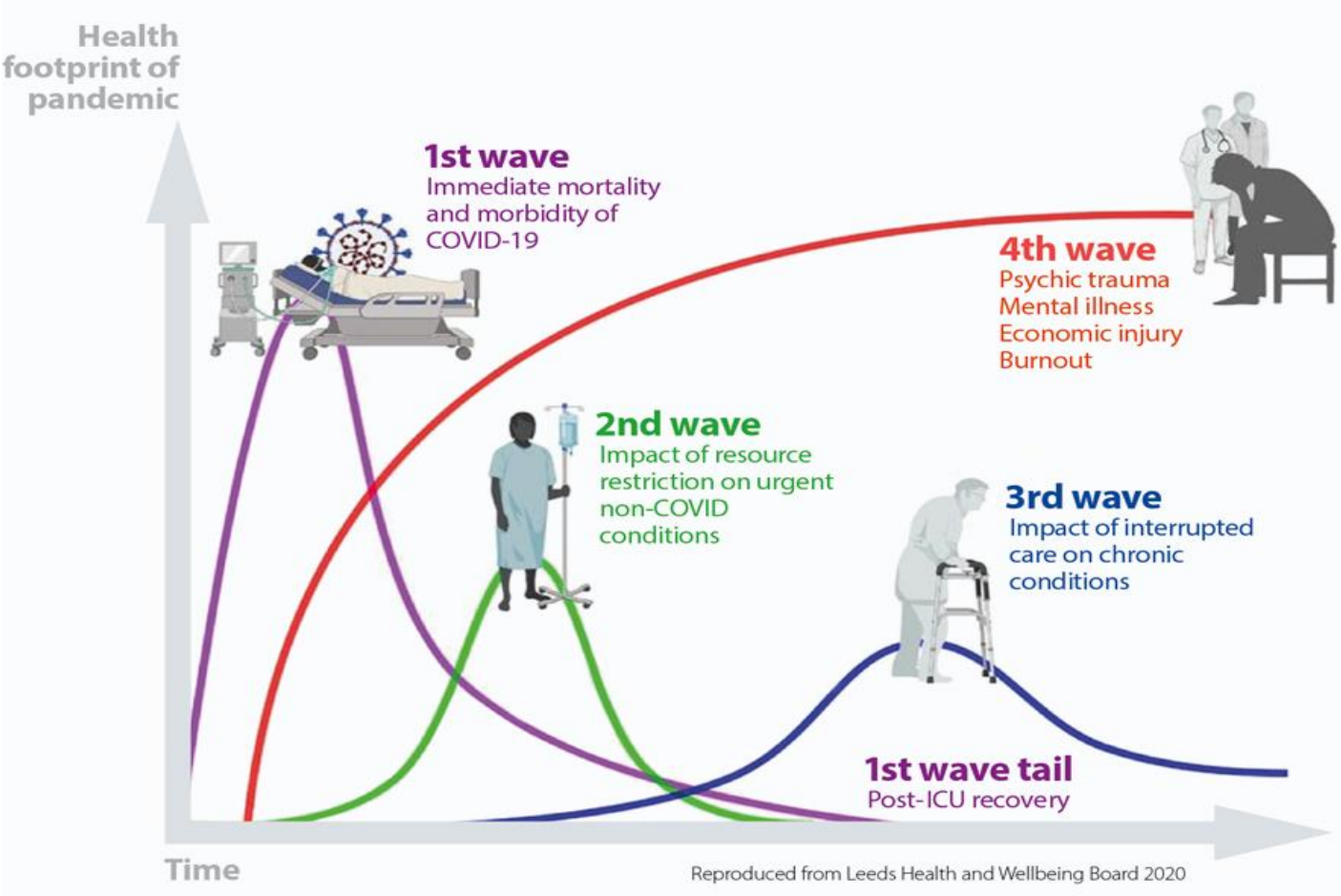
- COVID-19 shone a harsh light on the health and wider inequalities that persist in our society

- COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination

- The impact of the virus has been particularly detrimental on
  - people living in areas of high deprivation,
  - people from Black, Asian and minority ethnic communities (BAME),
  - older people,
  - men
  - those with a learning disability and others with protected characteristics.

- **But. Health Inequalities existed long before COVID-19**


Direct COVID-19 effects
Disproportionally higher infection rate in more deprived areas
Disproportionate long-term impact in survivors of COVID-19
Increased incidence of mental ill health; plus decline in mental wellbeing for those with existing mental health conditions, due to COVID-19 crisis and lockdown
Indirect COVID-19 effect from NHS services diverted to COVID response
Lack of usual healthcare services
COVID-19 impact
Indirect COVID-19 effect from poor access
Reduced access for non-COVID health problems, including difficulty to access virtual support/reduced home visits
Unequal access to remaining services, eg:
those shielding at home/extremely vulnerable
digital exclusion
barriers for those with learning disabilities and autism with unequal experience of access via these new routes
Those with physical or sensory impairment/disability
People who are homeless or move frequently due to insecure housing/hidden homelessness
Effect on wider determinants and wider social care support systems
Detailed below



Outstanding care for people in ways which matter to them

Health Inequalities

But. Health Inequalities existed long before COVID-19….

What are Health Inequalities?

"Health inequalities are avoidable, unfair and systematic differences in health between different groups of people" (Kings Fund, 2020)

Health inequalities can therefore involve differences in:

- health status, for example, life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

Differences in health status and the things that determine it can be experienced by people across a range of groups:

- Socio-economic factors such as income
- Geography such as regions, or urban or rural
- Specific characteristics often protected by law, such as ethnicity, sex or disability
- Social excluded groups, such as the homeless

https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Wider determinants of health

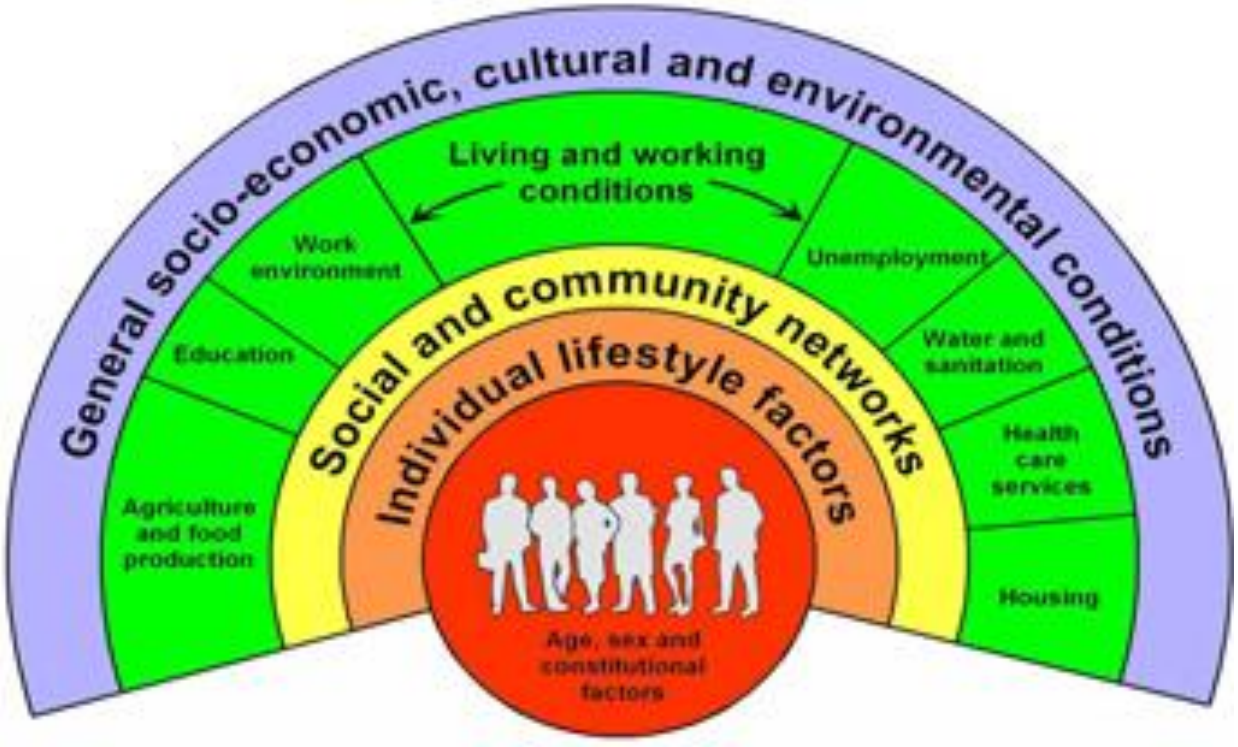
Non-medical factors account for 80-90% of a person's health

First 1000 days account for about 50-60% of that 80-90%

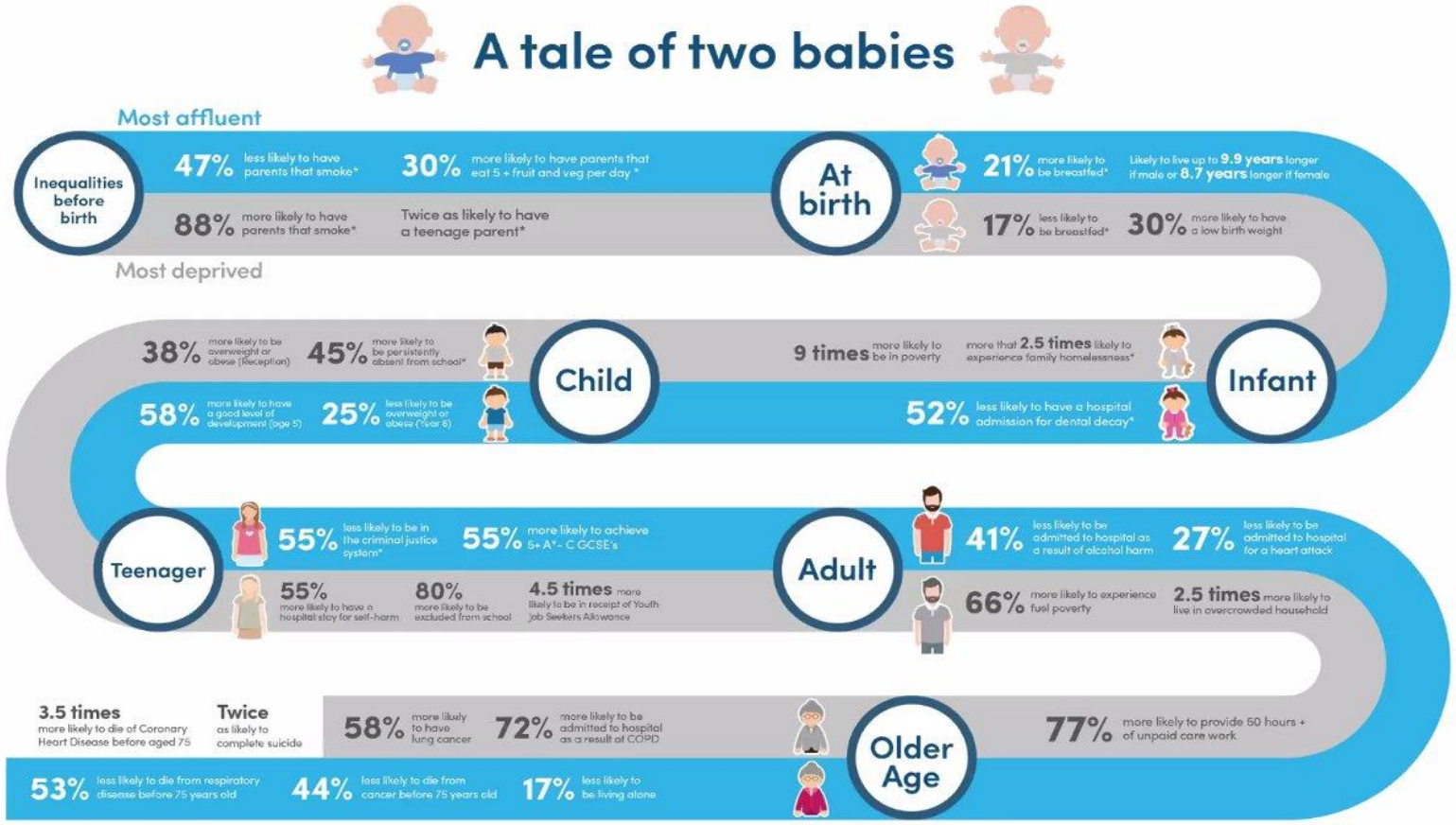





https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/
https://www.americanactionforum.org/research/understanding-the-social-determinants-of-health/
http://eprints.lse.ac.uk/6302/1/Social_Mobility%2C_Life_Chances%2C_and_the_Early_Years.pdf



Dalgren and Whitehead (1991)



Outstanding care for people in ways which matter to them

DCH Communities

Demographics

28% population is 65+ (18% nat.), 1 in 3 in some districts

Deaths outnumber births – inward net migration drives population growth

Next 25 years; 1.5% increase in 65+, decline in working age and 0-15 year olds

By 2040 1:1 ratio of working age and pension age in Dorset

GVA Impact

4/5s of our workforce lives in West Dorset

£169m in GVA to local economy,

1.58 multiplier on £ and 1.53 on jobs

Rurality and Deprivation

46% of Dorset population live in 'rural' areas

Barriers to housing and essential services are significant due to rurality and distance

66 areas in Dorset in 20% most deprived nationally on this measure – 21 in West Dorset, 20 in North Dorset

Life Expectancy

Average difference in life expectancy of 6 years for men and 5.2 years for women between least and most deprived areas

Life expectancy at birth (2013-17)

Melcombe Regis – Female 79 Male 75

Dorchester South – Female 87.8 Male 85.3

Community Engagement

Over £2m in fundraising over last 3 years

228 volunteers at DCH

Pears Foundation grant to attract young volunteers

Workforce Stats

88% of average national earnings

12% workless households

Lower end house prices 10 times higher than lower end earnings

Outstanding care for people in ways which matter to them

8 NHSEI Actions

- Protect the most vulnerable from COVID-19
- Restore NHS services inclusively
- Develop digitally enabled care pathways in ways which increase inclusion
- Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
- Particularly support those who suffer mental ill-health
- Strengthen leadership and accountability
- Ensure datasets are complete and timely
- Collaborate locally in planning and delivering action

Dorset ICS Health Inequalities Approach

- Addressing Health Inequalities identified as a Tier 1 Priority of the Dorset ICS
- Dorset ICS SRO – Patricia Miller
- Dorset ICS Health Inequalities Group established – 1st meeting in October, bi-monthly
- Position Statement from first HI System Group
- Community engagement to develop a population and place-based approach to HIs in Dorset will be at system level rather than organisation level

DCH Approach

- System and place based work driven by ICS Health Inequalities Group which DCH work will link in to (see governance).

- DCH HI Programme scope is therefore focussed on changing culture and practice within DCH with a focus on
  - Minimising detrimental impact on health of race, deprivation (particularly rural), physical and mental disabilities, and LGBTQ+
  - Reducing the inequalities /symptoms of which drives most demand for DCH services
  - early years and childhood and transition services

- The Programme Vision is the DCH Vision:

  "DCH will be at the heart of improving the well-being of our communities"

- The aim of the DCH Health Inequalities Programme is:

  "To ensure that we take every opportunity at DCH to ensure equity of access and outcomes for all our communities"

DCH Approach

- The objectives of the DCH Health Inequalities Programme are to:
  - Recognise, support and enhance existing DCH work
  - Ensure we have the right data, reporting and insights to inform all our decision-making and ensure HIR are considered in all we do
  - Educate and inform all our staff about the impact of Health Inequalities with a particular focus on health literacy
  - Ensure health inequality reductions (HIR) are considered as part of our Quality Improvements
  - Embedding prevention and health inequalities reductions (HIR) approaches within our day to day business, operational processes, digital processes and clinical pathways (e.g. MECC)
  - Use our position as an Anchor Institution to enhance our social value contribution
  - To support staff who may experience health inequalities directly or indirectly

DCH Approach

Recognise, support and enhance existing DCH work	- Map existing metrics - Map existing activity at DCH and build a directory of services and library of good-practice and case studies from DCH	
Ensure we have the right data, reporting and insights to inform our decision-making	- Baseline existing data collection - Identify most deprived areas and rural pockets of deprivation and isolation - Reporting to committees etc consistently includes HI metrics and measures (e.g. waiting list breakdown) - Review complaint data against post-code. Could we collate ethnicity data? Any correlation between compliants re. virtual appointment and HI factors such as race, deprivation, LDs etc - Build assessment of impact on HI into our decision-making processes (e.g. templates and corporate front-sheets etc) - Use Population Health Management to inform focus and decision-making at corporate and clinical level	
Educate and inform all our staff about the impact of Health Inequalities and health literacy	- Education programmes for staff on what HI are and what staff can do/how they can recognise patients at risk of HI – CAN WE DO ACROSS ICS - Roll-out health literacy training and support – cultural competence	
Ensure health inequality reductions (HIR) are considered as part of our Quality Improvement	- SV/HIIA Impact Assessment for all CIPS/QIs - Build a SV Calculator - Build HI consideration into templates	
Embedding prevention and health inequalities reductions (HIR) approaches within our day to day business, operational processes and clinical pathways	- Make Every Contact Count approach - Patient Activation Measure - digital pathways to consider HI impact - Long term conditions focus	
Use our position as an Anchor Institution to enhance our social value contribution	- AI/Social Value Programme	
To support staff who may experience health inequalities directly or indirectly	- Staff health and well-being programme - Build a programme of support for staff who may be at risk – e.g. food poverty, fuel poverty etc - Consider tailoring of all staff programmes and policies to address HIs	

Metrics to be developed/What do we need to know/HI Dashboard?

Wider determinants/proxys which give us sense of improving/worsening problem

- Education, economic markers, air quality, homelessness, housing waiting lists , social care referrals

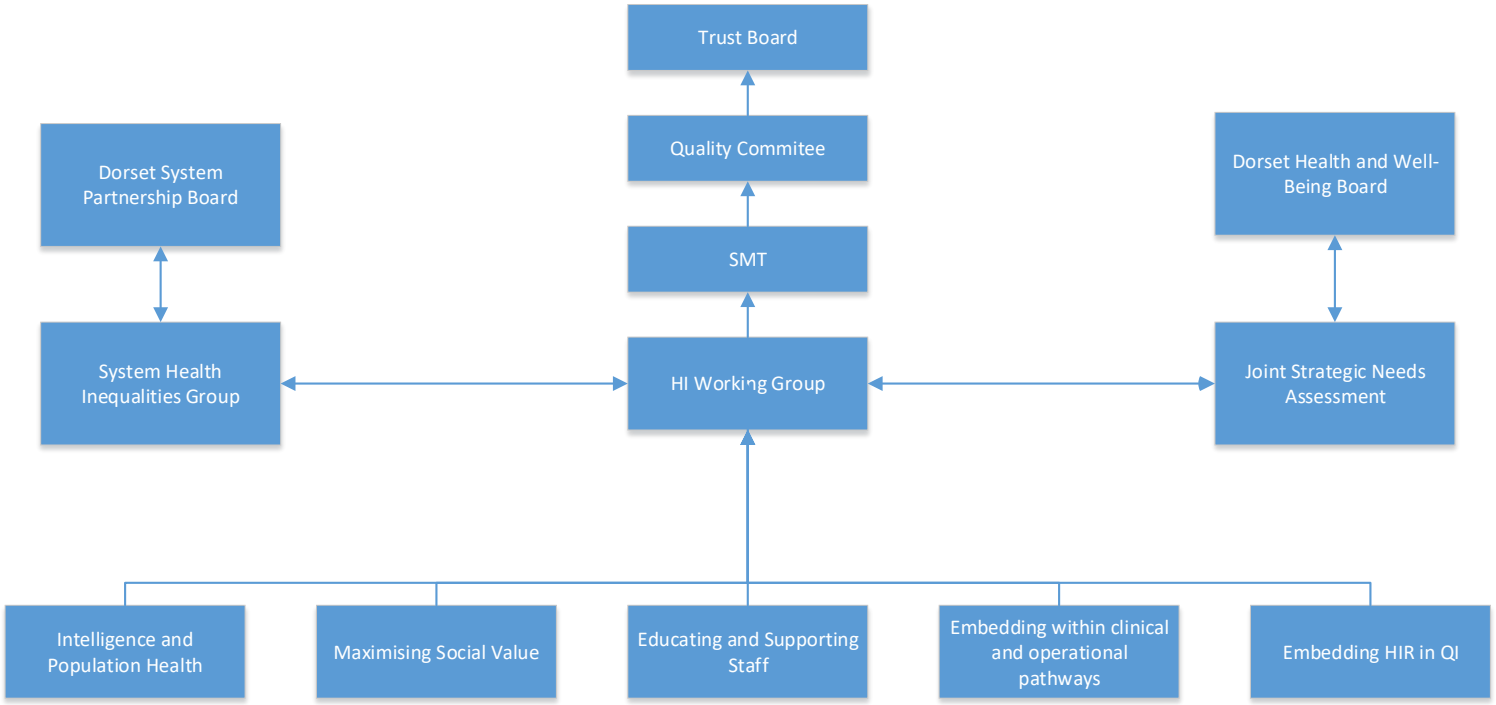
Staff

- Breakdown of staff by postcode, ethnicity, age, gender, protected characteristics
- OH data – trends
- Training and education rates on HI
- Workforce risk assessment by demographic characteristics and staff groupings
- report on workforce COVID-19 test results, with point prevalence at given time intervals by demographic characteristics and staff groupings

Patients

- Unwarranted variation in outcomes across key specialities
- Demand and activity drivers
    - What conditions (and causes of conditions) driving acute demand/activity – JSNA links
    - Remote consultation rates and any changes in access based on comparison with histotrical consultation rates
    - Admission rates for heart attacks, strokes, and other conditions associated as being caused by HIs
- Waiting lists – Elective, Cancer, Diagnostics and O/Ps
    - Break-down by postcode, ethnicity, age, gender, other protected characteristics
- PALS data
    - Complaints by post code, ethnicity and other protected characteristics
- Social
    - Safeguarding and Domestic violence referrals within Trust
    - Mental health presentations at ED

Governance/Project on a Page



Outstanding care for people in ways which matter to them

Resource and Funding

- Clinical Lead @ DCH – 1 PA per week
- Exploring HI Research Fellow
- Band 7 – Health Inequalities Programme Officer
- Supported by T&I infrastructure

- Funding
  - Existing T&I budget
  - NHS Charities Together funding

Table 1 Selected impacts of wider determinants on our health

Sector	Examples
Income	To be updated.
Housing	Poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. As external temperature falls, death rates rise much faster for those in the coldest homes. Households from minority ethnic groups are more likely than White households to live in overcrowded homes and to experience fuel poverty.
Environment	Access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Levels of access are likely to be worse for people in deprived areas, and for areas with higher proportions of minority ethnic groups. Exposure to air pollutants is estimated to cut short 28–36,000 lives a year in the United Kingdom. Exposure has been linked to both deprivation and ethnicity. For example, within the most deprived areas of London, people from non-White groups have been found to be more exposed to high concentrations of nitrogen dioxide, one of the main pollutants associated with traffic fumes.
Transport	Those living in the most deprived areas have a 50 per cent greater risk of dying in a road accident compared with those in the least deprived areas. Children in deprived areas are four times more likely to be killed or injured on the road than those in wealthier areas.
Education	On average among 26 OECD countries, people with a university degree or an equivalent level of education at age 30 can expect to live more than five years longer than people with lower levels of education.
Work	Unemployment is associated with lower life expectancy and poorer physical and mental health, both for individuals who are unemployed and for their households. The quality of work, including exposure to hazards, job security and whether it promotes a sense of belonging, affects the impact it has on both physical and mental health. Non-White groups experience higher levels of work stress, controlling for other demographic factors.

https://www.kingsfund.org.uk/publications/what-are-health-inequalities

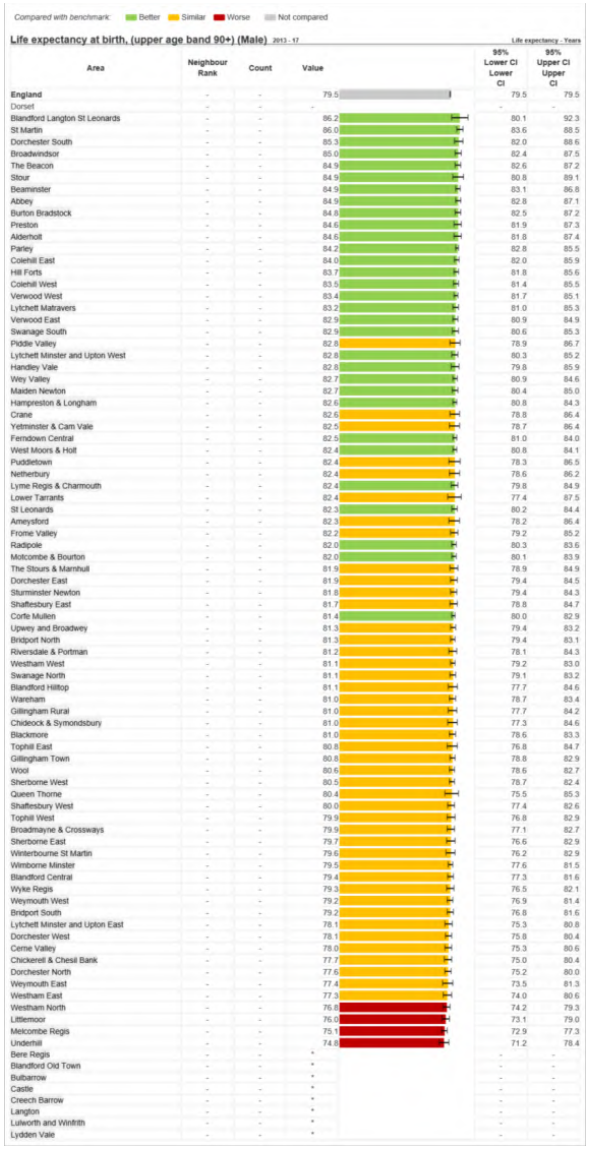
Slides from PHD

UTLA level HLE masks variation within the councils

Dorset Life expectancy at birth

Males – just over 11 years between Blandford Langton St Leonards (86.2 years) and Underhill (74.8 years)

https://fingertips.phe.org.uk/local-health#page/3/gid/1938133185/pat/202/par/E06000059/ati/8/are/E05010749/iid/93283/age/1/sex/1/cid/4/tbm/1/page-options/ovw-do-0_car-do-0

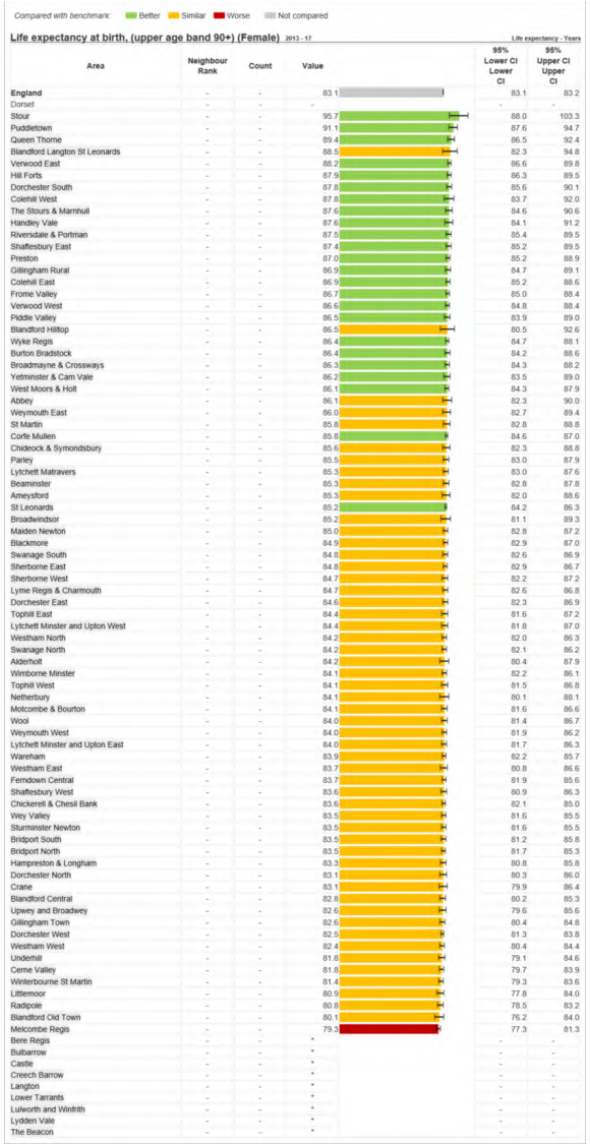


UTLA level HLE masks variation within the councils

Dorset Life expectancy at birth

Females = 16 years difference between Stour 95.7 years and Melcombe Regis 79.3 years

https://fingertips.phe.org.uk/local-health#page/3/gid/1938133185/pat/202/par/E06000059/ati/8/are/E05010749/iid/93283/age/1/sex/2/cid/4/tbm/1/page-options/ovw-do-0_car-do-0

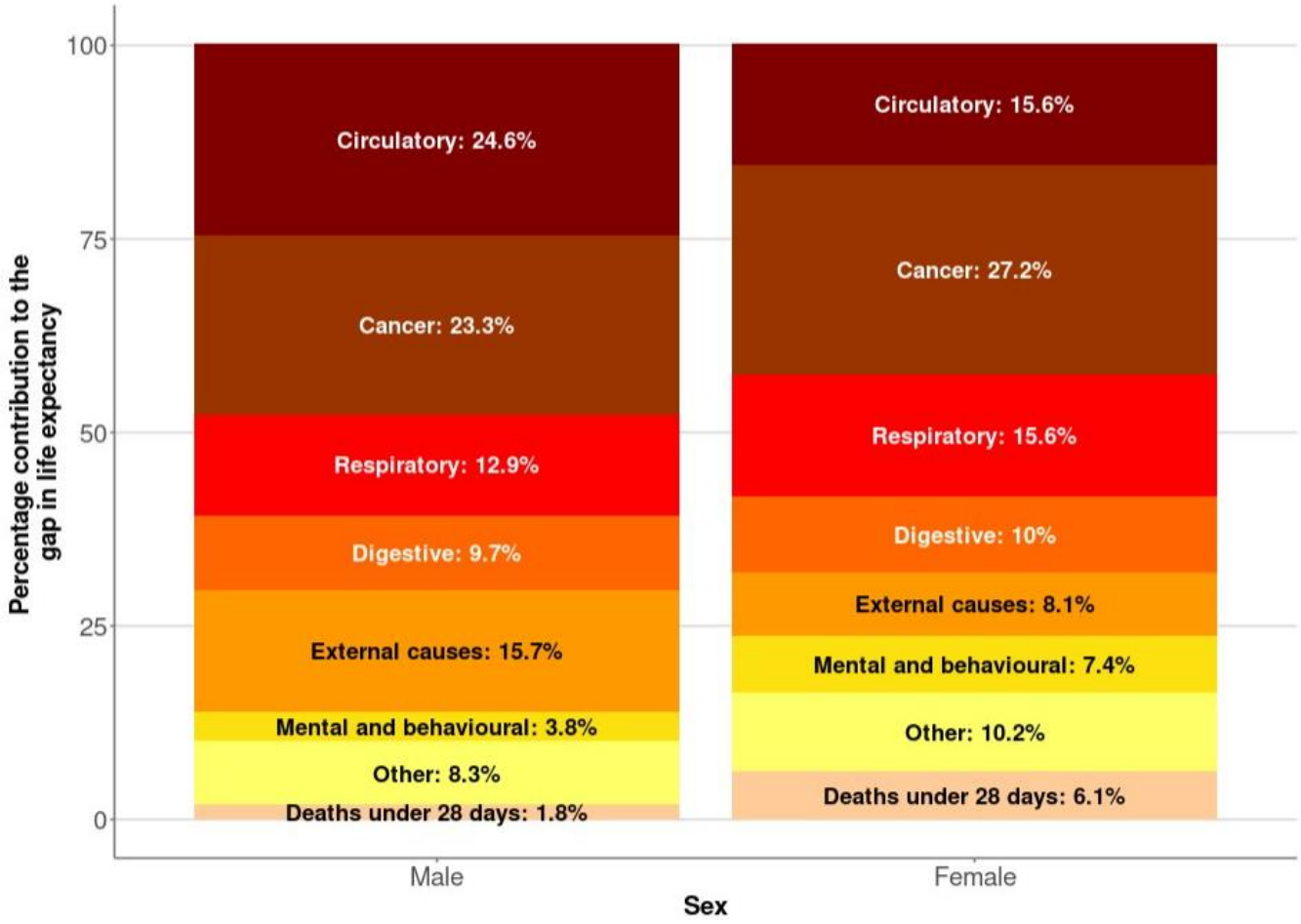


What causes health inequalities?

- This ‘segment’ tool gives the (medical) causes of deaths
- Then there are the causes of the causes …

- https://analytics.phe.gov.uk/apps/segment-tool/

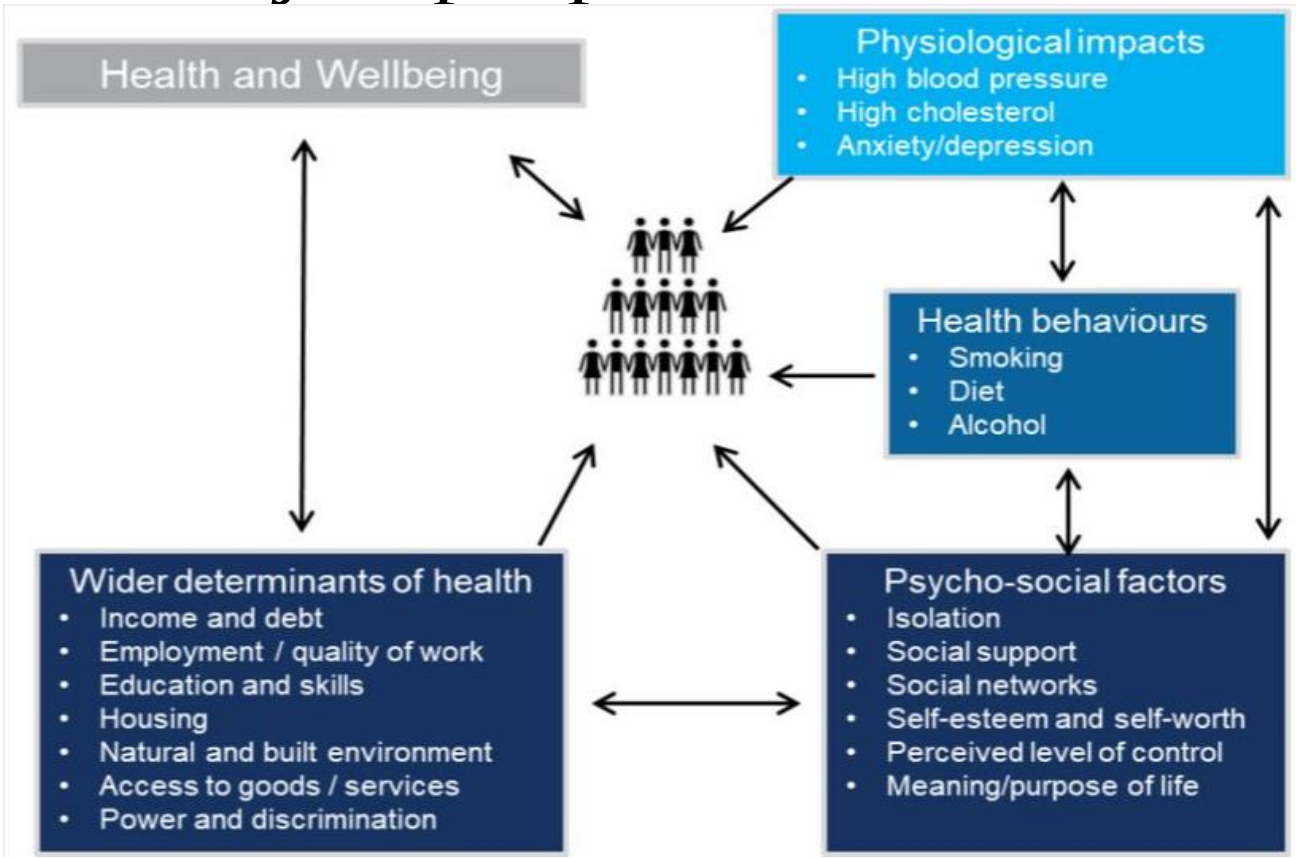
Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Dorset STP, by broad cause of death, 2015-17



What causes health inequalities: *treating place not just people*

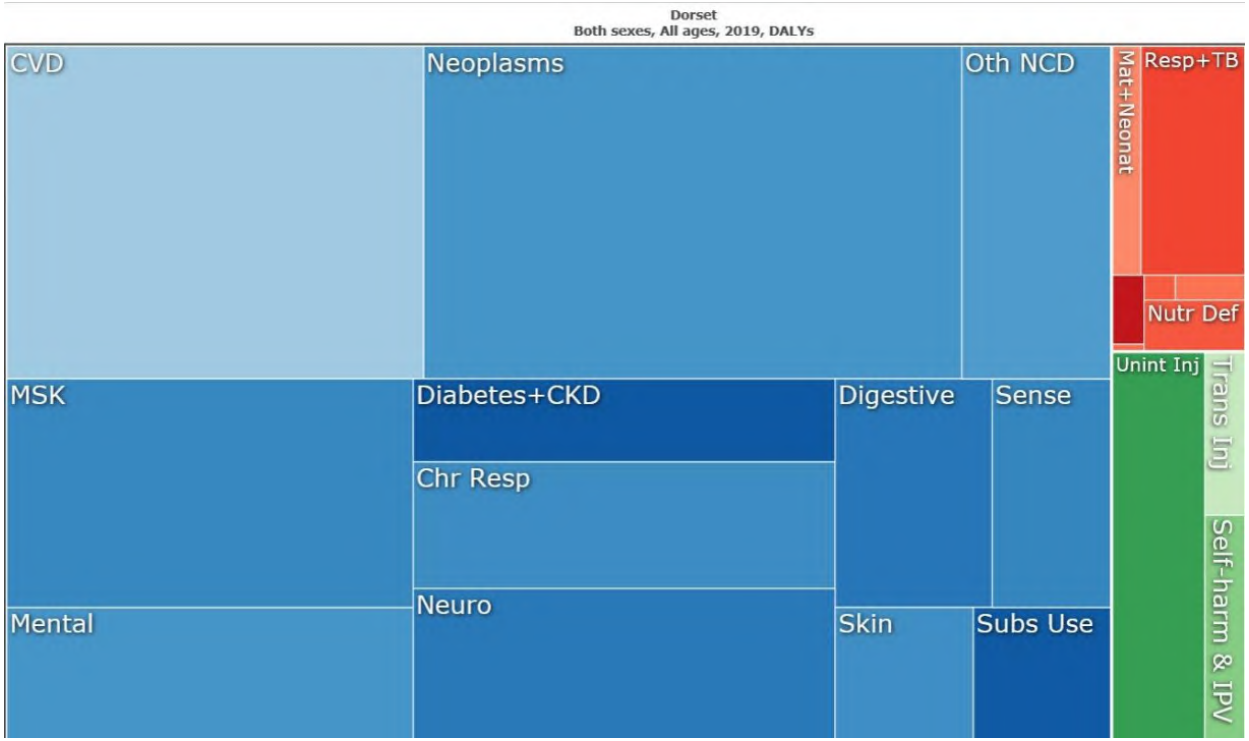
- Labonte model (adapted) gives a clear conceptual framework which analyses the causes, and opportunities for action
- Highlights why interventions must focus on treating place and not just people.
- Acting on only one factor is likely to provide a partial and incomplete response to the situation.

https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report



Why CVD?

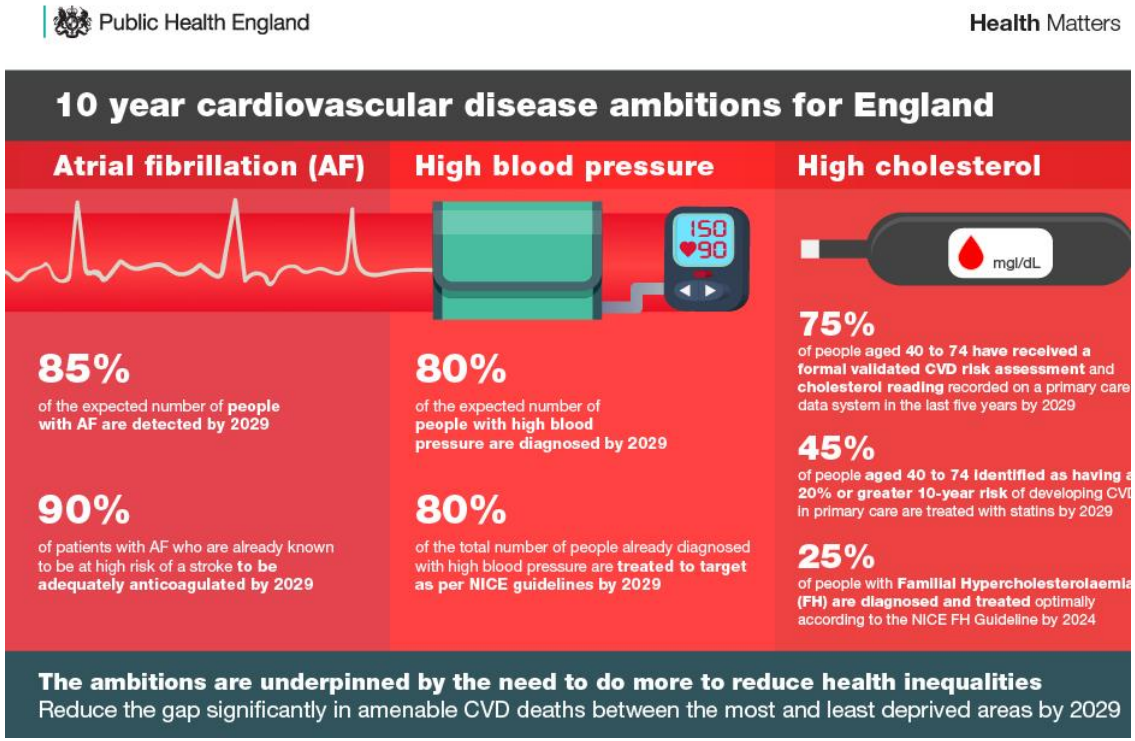
- Latest GBD data shows CVD as the 2nd highest cause of loss of DALYs in Dorset
  - 16% of total DALYs from CVD
  - Neoplasms 21%



https://vizhub.healthdata.org/gbd-compare/

Focussing in on CVD

- The ABC of CVD prevention:
  - Atrial fibrillation
  - Blood pressure
  - Cholesterol
- To complement the NHSLTP, the National CVD Prevention System Leadership Forum (CVDSLF) agreed specific ambitions for the detection and management of the high risk conditions



https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/health-matters-preventing-cardiovascular-disease

Candidate CVD indicators

- Indicators from : CVD primary care intelligence pack, PHE 2017 covering
  - CVD Prevention
  - Hypertension
  - Stroke
  - Diabetes
  - Kidney
  - Heart disease
- PHE Fingertips General Practice profiles
  - CVD indicators

Meeting Title:	Board of Directors Part One
Date of Meeting:	31 March 2021
Document Title:	**Covid-19 Recovery Framework**
Responsible Director:	Nick Johnson – Deputy Chief Executive
Author:	Nick Johnson – Deputy Chief Executive

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT	04th March 2021	Simplified governance
SMT	17TH March 2021	Comms, measures for staff recovery
FPC	23rd March 2021	Recommended to Board

Purpose of the Paper	For approval
Summary of Key Issues	As the immediate Covid-19 pressure subsides and vaccination numbers increase, planning the recovery of staff and services must commence. The attached slides set out a proposed framework for overseeing the recovery which will need to equally consider the recovery of staff and recovery of services.
Action recommended	For the Board of Directors to: • approve the Recovery Framework set out in the attached paper.

Governance and Compliance Obligations

Legal / Regulatory	Yes	Statutory obligation for recovery. Regulatory requirement for recovery of services
Financial	Yes	Commitment of resources to aide recovery but no direct implications as a result of this paper
Impacts Strategic Objectives?	Yes	Alignment of immediate recovery actions to longer term strategic aims
Risk?	Yes	Significant risk arising from covid. Risk to organization of failure to 'recover'
Decision to be made?	Yes	As per recommendations
Impacts CQC Standards?	No	No
Impacts Social Value ambitions?	Yes	Opportunity for significant SV contributions. Workstreams will consider.
Equality Impact Assessment?	No	Significant impacts and links to Health Inequalities agenda. EIAs will be completed by Recovery workstreams.
Quality Impact Assessment?	No	Not directly as a result of this report.

Recovery Framework

DRAFT

Outstanding care for people in ways which matter to them

Context

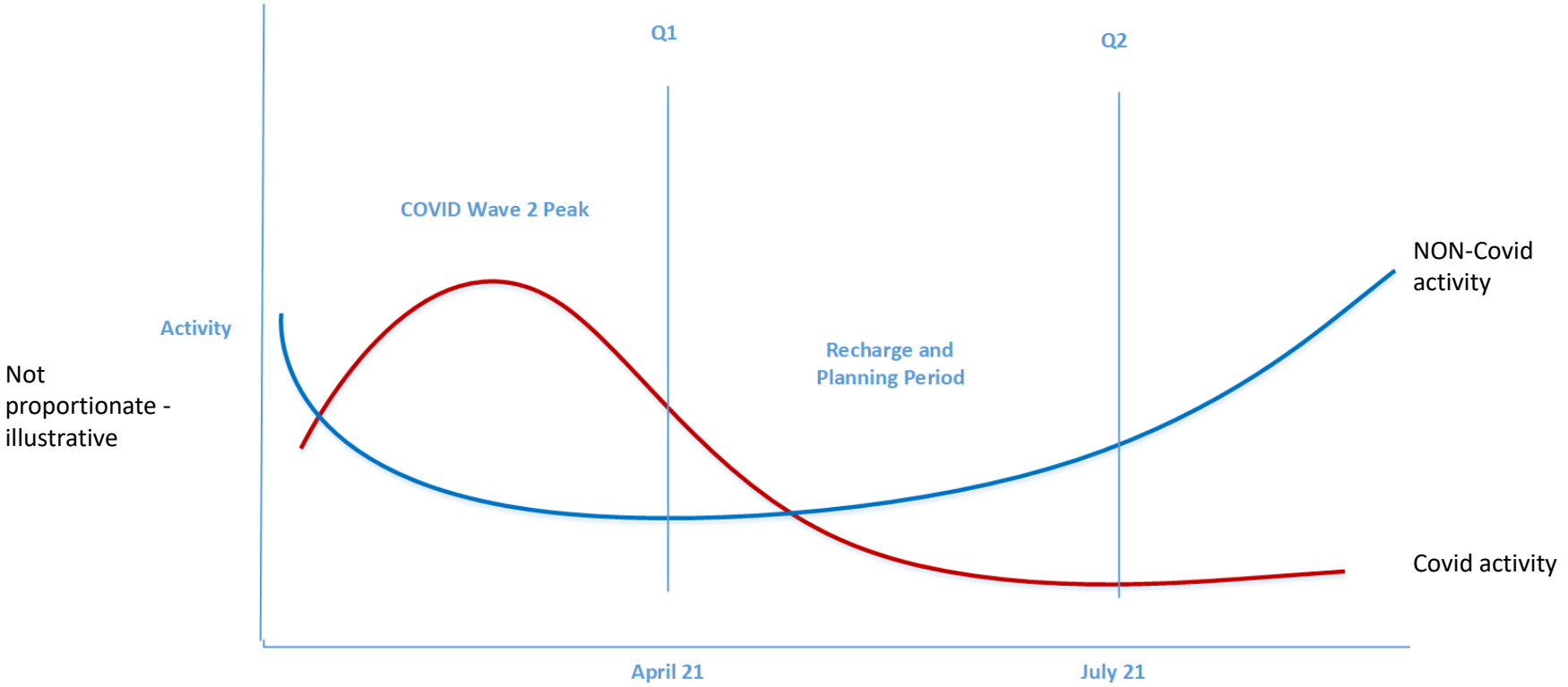
- As the immediate Covid-19 pressure subsides and vaccination numbers increase, planning the recovery of staff and services must commence
- The following slides set out a framework to guide DCH's approach to the Recovery
- This approach will evolve and be informed by any System and National planning guidance as they are issued

Key principles/messages

- Recovery = recovery of staff and services
- Our priority is the recovery and well-being of people
- We will plan for the sustainable recovery of services – a considered and planned recovery of services will benefit more patients in the medium to long-term
- The process will be long-term for both staff and service recovery
- Focus on prioritising by clinical need and priority; service recovery is about being there for our patients not simply meeting national requirements
- Recognition that staff and services experienced different pandemics and recovery needs will be variable

Key objectives

- To establish and embed a range of offers which will provide ongoing recovery and well-being support to staff which prioritise retention
- To manage the balance between staff recovery and well-being and the recovery of services to meet patient need
- 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 equality in health outcomes into restart processes
- Look forward and learn from what's been successful here and elsewhere and share and spread



Outstanding care for people in ways which matter to them

DCH Tests	We retained our resilience to deal with Covid	We did everything we could to minimise harm to patients	We delivered time-critical elective activity prioritised on clinical need	The innovation and improvements we made were retained, refined and rolled-out	We included everyone and worked together with kindness	We are providing more effective, efficient and quality care	We addressed health inequalities & recognised our role as an anchor institution

	Area	Priority 1 - Critical	Priority 2 - Urgent	Key Metric/Measure
Safe, Effective, Response	Cancer	- Full operation of all cancer services	**- Endoscopy access**	Clinical need
	Non-elective/Urgent Care	- Improving Flow - Minimising No Reason to Reside	- Alternative pathways to ED **- Discharge to Assess – HOME FIRST 100 Day Plan**	
	Elective and diagnostics	- Most clinically urgent - Minimise 52 Week Waiters	- Orthopaedics - Ophthalmology - Oral surgery - MaxFacs - Audiology **- Cardiology?**	
	Manging Covid	- IPC Measures - Covid Vaccine	- National Patient Safety requirements - Testing Capacity and Capability	
Well-led, Caring	Staff and Workforce	- Staff well-being - Culture Review	- EDI	
	Supporting delivery and planning for the future	- Strategic Refresh - Health Inequalities - ED15 - Integrated Services Hub (ED, ICU) OBC	- Quality Improvement - Digital Strategy	
	Finance	- Financial Plan - CIP identification and delivery		

Risk Appetite, Board Assurance Framework and Corporate Risk Register

NHSEI Winter 21 and 21/22	Respond to CV19	CV19 Vaccination	Maximise non-CV19 Activity	Emergency demand and winter	Well-being
DCH Values	Integrity	Respect	Teamwork	Excellence	

'Roadmap' – graphic once dates

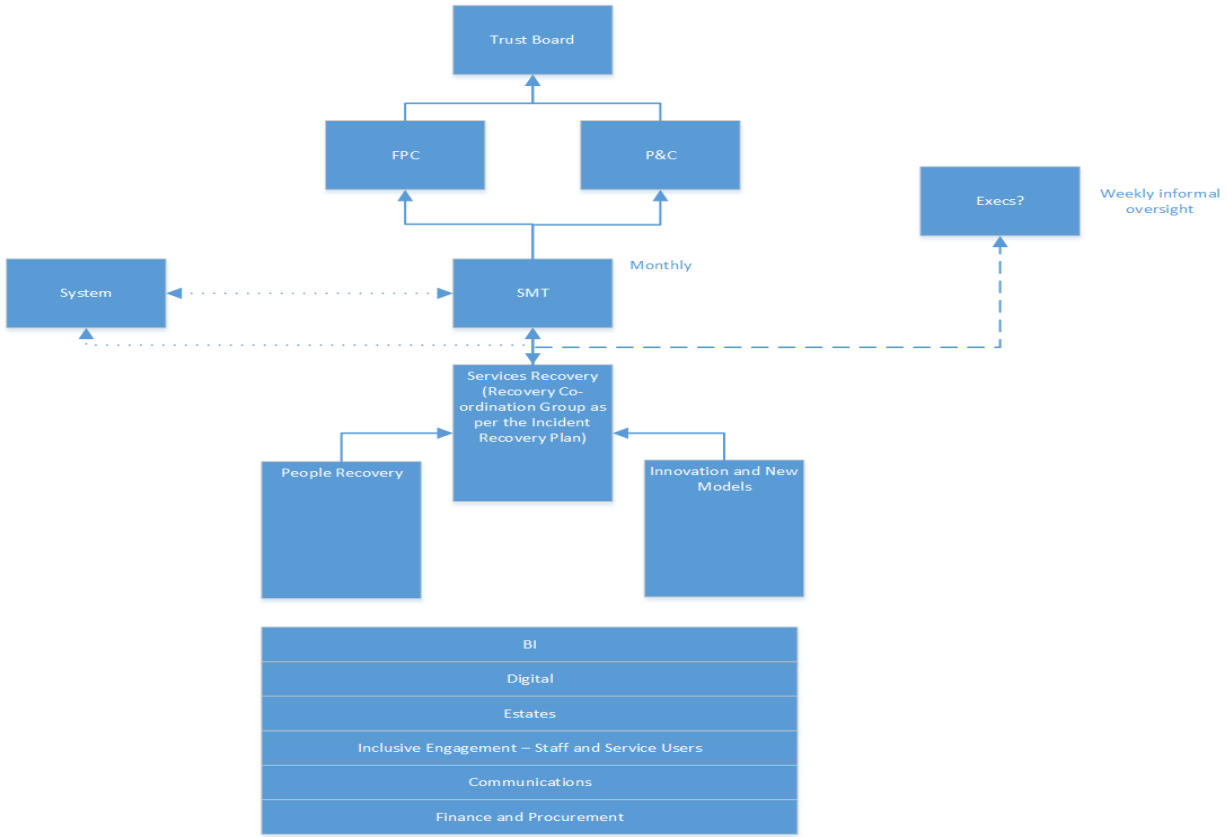
March	April	May	June	July	August	September	October
-Consolidate Covid capacity and hand-back -Continue to prioritise activity based on clinical need -Beginning planning for Q2 activity ramp-up 8th March - Work on new MSCP starts - Work on SDEC starts - Work on orthopaedic outpatients - Enabling work for increased ED Capaicyt starts	-National Planning Guidance issued -Dorset ICS Prioritisation process completed	- Plans for service recovery finalised	-21st June – Step 4 – Restrictions lifted -Expanded Ortho outpatients opens -Work commences on expanding existing ED				-All services operating at capacity

Outstanding care for people in ways which matter to them

Working Groups

	People Recovery	Service Recovery	Innovation and new models
Exec Lead	Dawn Harvey Interim Emma Hallet	Inese Robotham	Nick Johnson
Management Lead	Emma Hallet/ Catherin Youers??	TBC – ???	Paul Lewis
Time-period before stand down and transition to 'BAU'	12 months	3-6 months (regular reviews, continue as necessary)	3 -6 months (regular reviews)
Areas of Focus	- Staff support and recovery - Staff competencies impact - Workforce supply	- Maximising existing capacity - Minimising clinical harm - Elective Services - Diagnostics - Cancer services	- Productivity gains - New O/P Models - New operational models - New ways of working – clinical and non-clinical - Digital solutions
Existing forums/groups	Staff Well-being Staff Testing	Phase 3 delivery group Divisional Configuration Operational T&F	
Key Issues/Actions?	Survey – what worked, what didn't, what will help your recovery Metrics/measures for staff recovery and well-being Competencies – e.g ortho Survey – what's most important to staff recovery? Team away days/reflection time	- *Core Recovery Coordination Group as per DCH Incident Recovery Plan* - Informed by national planning requirements - Incident Impact assessment - Dashboard and reporting - Weymouth theatres, Therapies	-Digital O/P -Learning from AHSN/elsewhere -Rapid review – what keep/what put back - Learning

Governance



Outstanding care for people in ways which matter to them

Next Steps

- What lessons can we learn from previous ‘restart’?
- Agree workstreams and workstream leads – mid-March
- SMT – March 17th
- Board – March 31st
- Each ‘workstream’ established and produces remit/ToR by end of March
- Action Plans developed – April 14th SMT
- Divisional Ops Plans developed – same as Business Planning process/requirement

Meeting Title:	Board of Directors
Date of Meeting:	31 March 2021
Document Title:	**Mortality Report: Learning from Deaths Qtr 3 2020/21**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	10th February 2021	None specific
Quality Committee	16th February 2021	Approved subject to amendments

Purpose of the Paper	To inform the Board of Directors of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI continued its improving trend during Q2 into Q3, to its lowest level within the 'as expected' range for at least 5 years. This report provides assurance that there are no other indicators to suggest standards of in-patient care are contributing to an elevated SHMI. Structured Judgement Reviews are being used by both Divisions to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses in care that are identified. In addition the DCH Medical Examiners review every death and highlight any obvious causes for concern.
Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website

Governance and Compliance Obligations

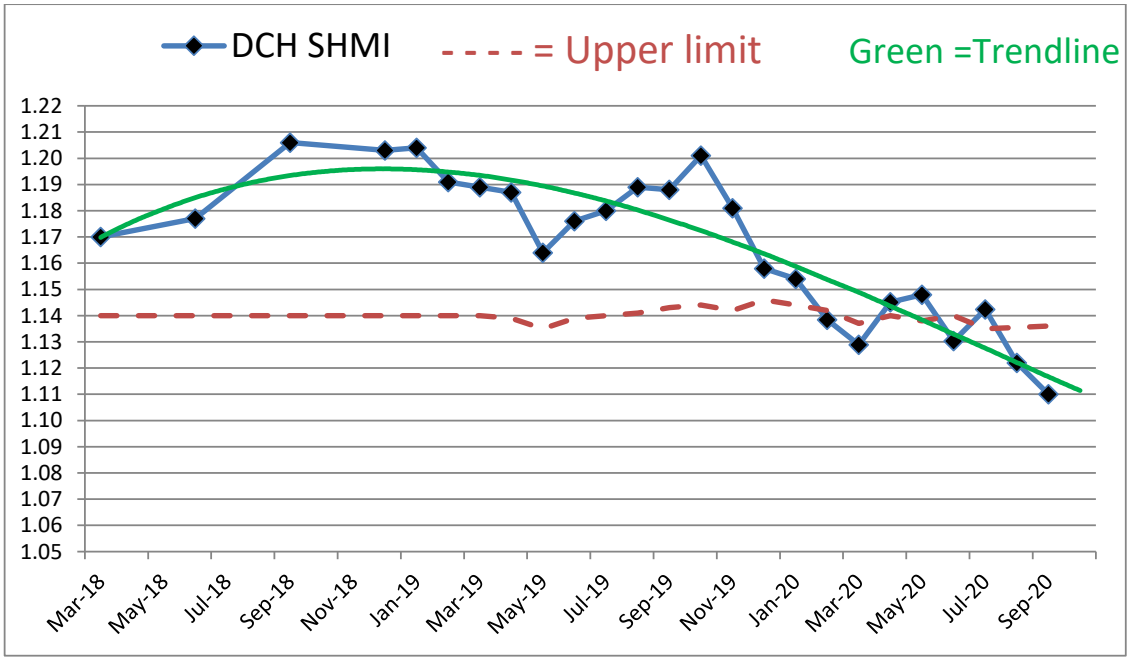
Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is adversely affecting the Trust's ability to assess quality of care • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor
Decision to be made?	N	
Impacts CQC	Y	An elevated SHMI raises concerns with NHS Improvement and the CQC.

Standards?		NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019 and is complete, but work continues. The reduction in SHMI is acknowledged.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

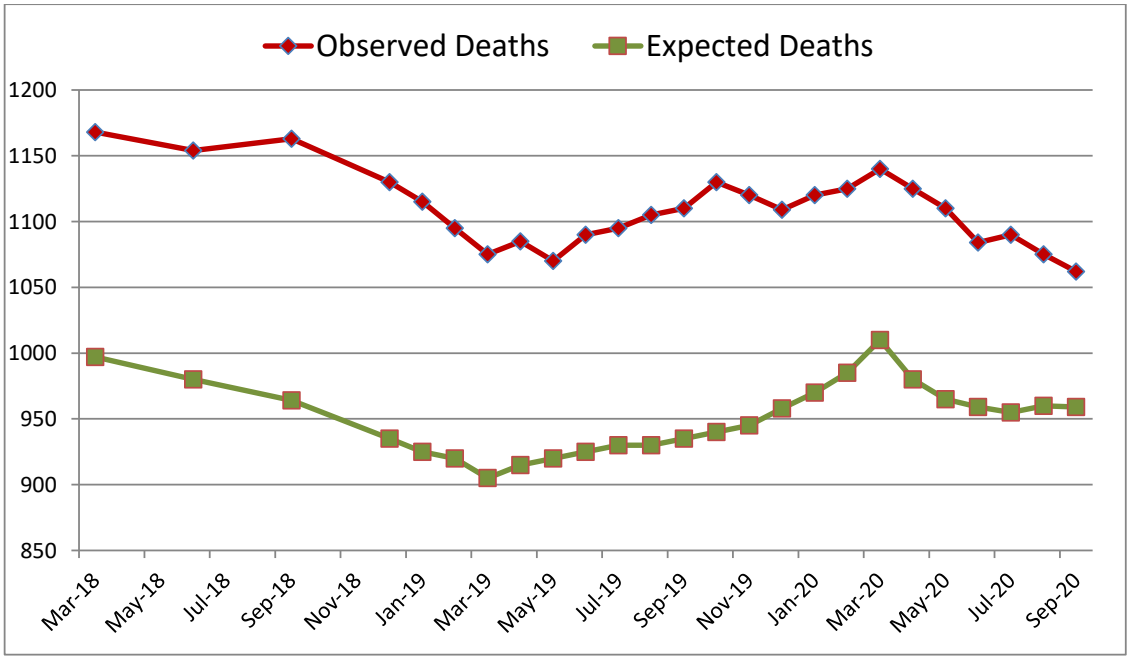
2.0 NATIONAL MORTALITY METRICS

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and occurring within 30 days of discharge. The SHMI for the rolling years from October 2019 to date shows a clear trend to improvement. The latest SHMI is at its lowest since December 2014.



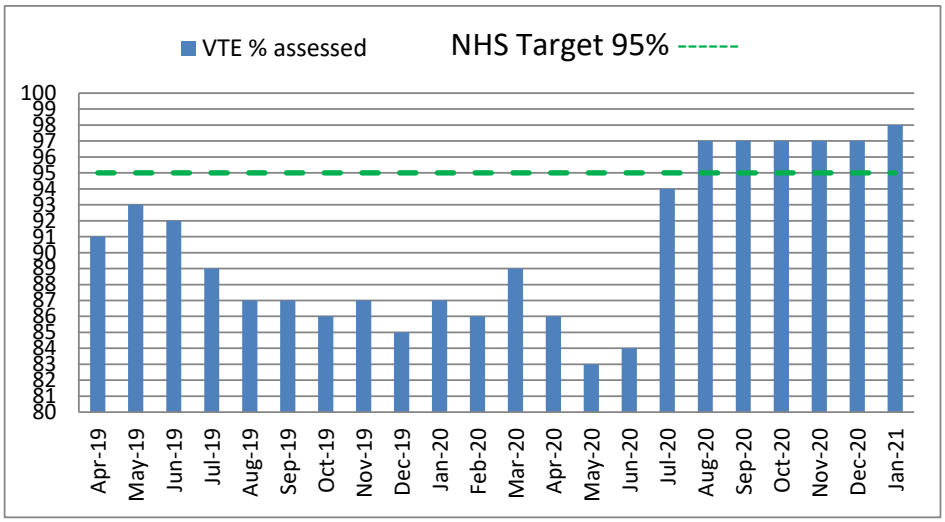
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding data). The chart below shows observed and expected deaths (predicted based on DCH coding) over the past 2 years (rolling years from March 18 to April 20).



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing. DCH VTE risk assessments reached 97% in August with the introduction of a more accurate reporting system, and have exceeded the 95% target for every month since then.



3.1 NCAA Cardiac Arrest data

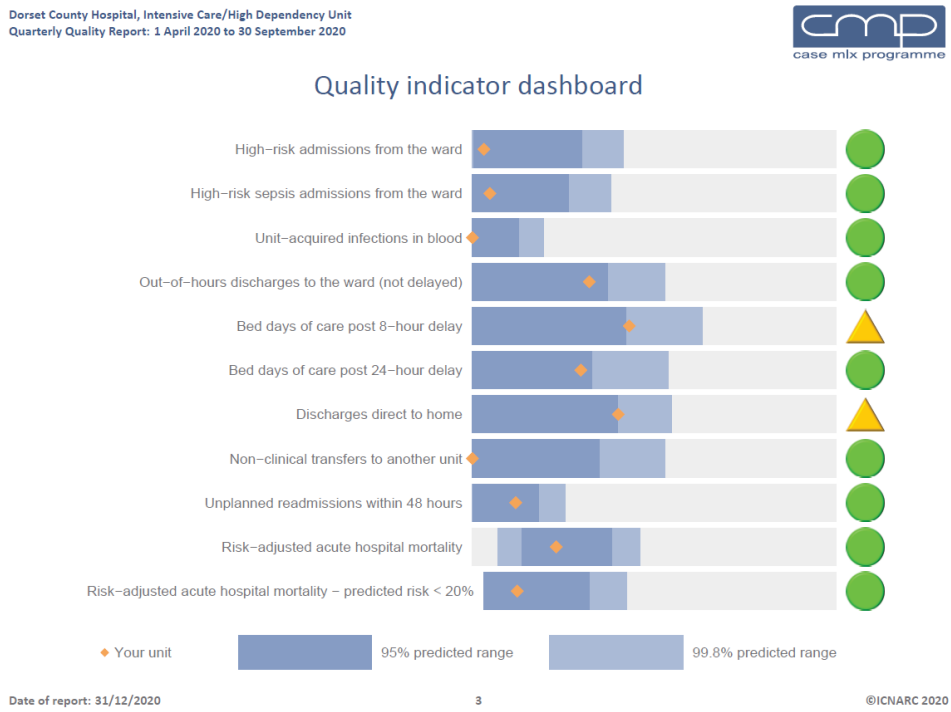
12 month Cardiac Arrest data for April 2019 to March 2020 was published in June 2020, and included in the previous Q1 report. The next data was expected in Nov 2020, but has not yet been published.

3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019

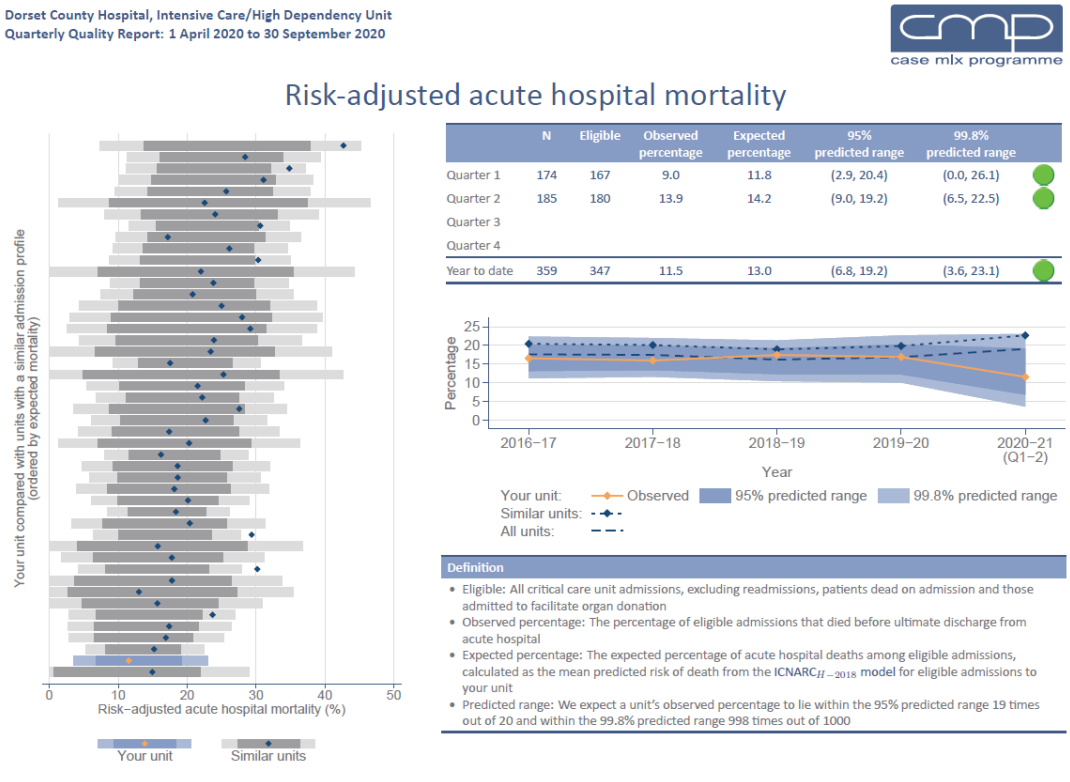
Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%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

The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average, but had a lower death rate and shorter length of stay, with fewer readmissions.

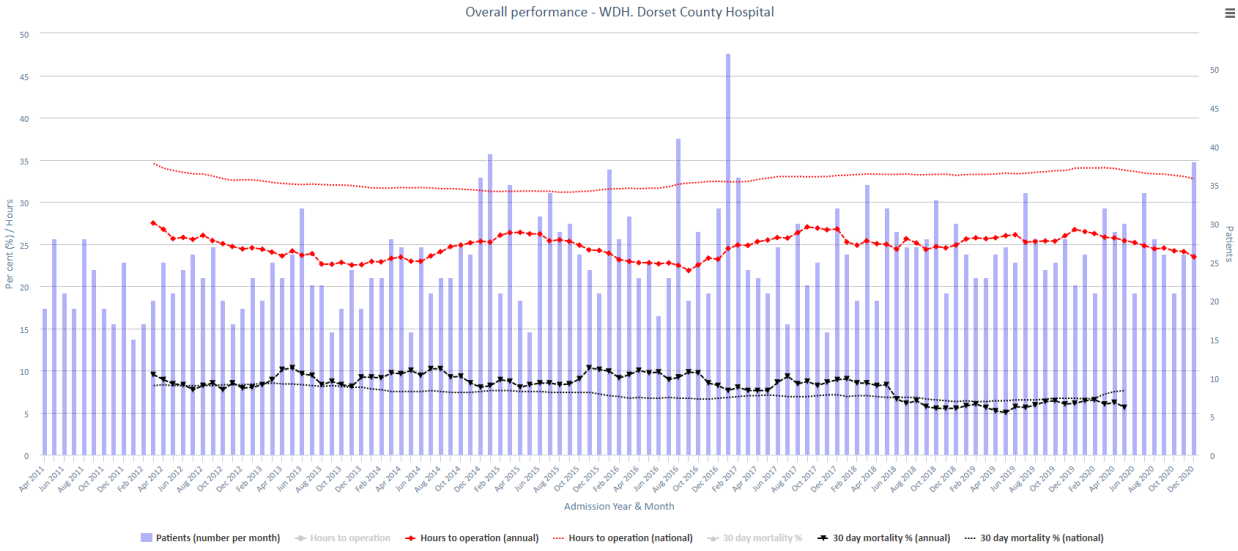
3.3 ICNARC Intensive Care survival latest data published 31 Dec 2020



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



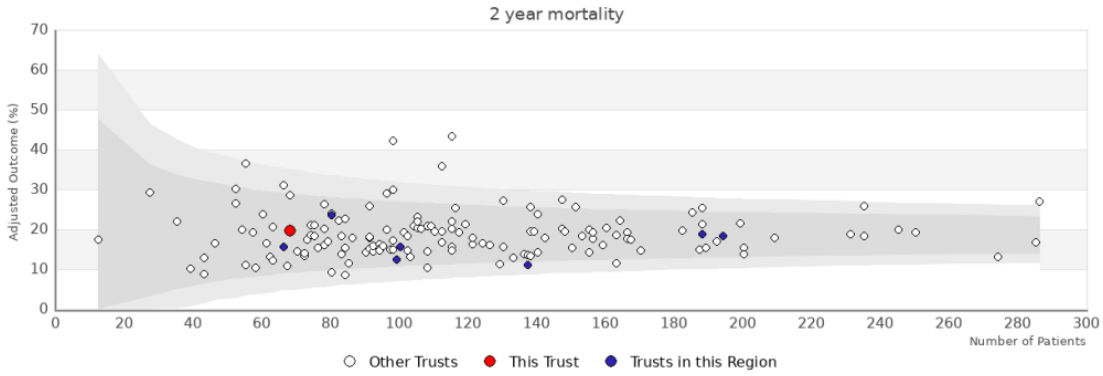
3.5 National Hip Fracture database to June 2020



Time from admission to operation remains significantly better than the national average (23.5 vs 32.7 hours), with 30 day mortality at 5.6% versus the national average of 7.6%.

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available 2 year survival data for 2018/19 admissions, compared to all other NHS Trusts, with other Wessex Trusts in dark blue.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	68	19.7%	19.3%

3.7 Getting it Right First Time; reviews in Q3

Two shortened virtual GIRFT reviews were undertaken at DCH during this quarter – Respiratory Medicine and South 6 Pathology. Full reports will be available in due course. From March 2020 most visits were suspended because of COVID-19. As a result of COVID wave 2, most visits have also been postponed for Q4.

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

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. A summary of the latest published data (totals for 2018/19 and 2019/20) is shown below. Data for 2020/21 is as yet incomplete:

Rate of Survival at this Hospital: Yearly Figures

Note: Data for the following years is not shown due to missing or incomplete data: 20/21

Rate of Survival Breakdown at this Hospital

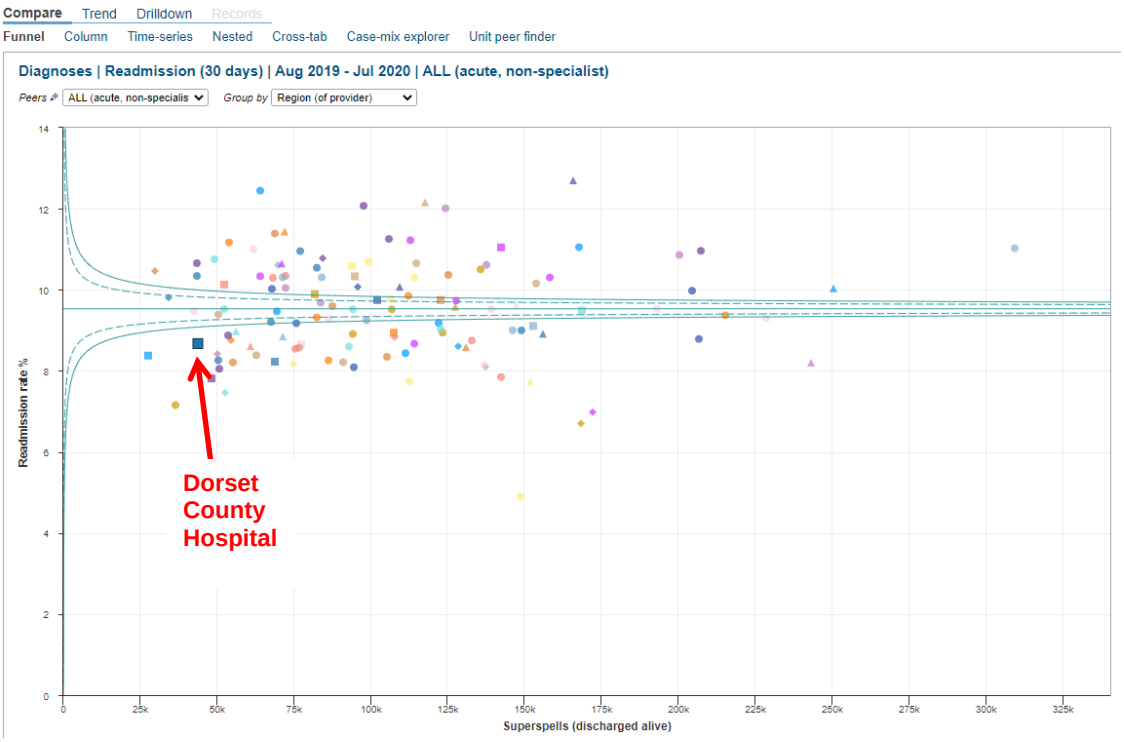
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	465	456	463	1.3	0.9
90 - 95	150	139	140	0.5	0.1
80 - 90	81	69	71	2.2	0.2
65 - 80	38	28	25	-8.0	-0.3
45 - 65	10	5	7	13.4	0.3
25 - 45	5	2	3	18.7	0.3
0 - 25	5	0	0	-13.5	-0.2
Total	**754**	**701**	**709**	**1.0**	**1.2**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resuscitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors.

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



3.10 Dr Foster Safety Dashboard

This dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during their in-patient stay. Where the confidence intervals include the national mean there is no statistical difference from the national average. DCH has a higher caesarean section rate than expected (4 versus 1.9; insignificant difference), a lower number of decubitus (pressure) ulcers (225 versus 230; insignificant difference),and fewer deaths in low-risk diagnosis groups (21 versus 44; significant difference).

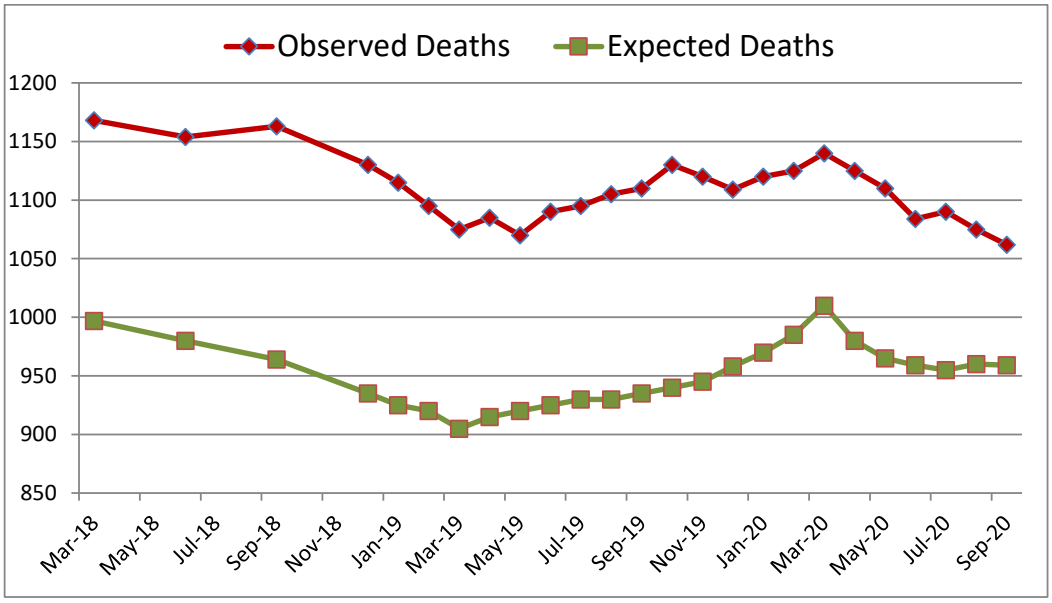
Period
History (Apr 2017 to most recent)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	31068	41	49.0	1.3	1.6	83.7
Deaths after surgery	204	9	14.7	44.1	72.2	61.1
Deaths in low-risk diagnosis groups	14705	21	43.5	1.4	3.0	48.3
Decubitus ulcer	3922	230	224.8	58.6	57.3	102.3
Infections associated with central line	5882	0	0.4	0	0.1	0.0
Obstetric trauma - caesarean delivery	395	4	1.9	10.1	4.7	215.9
Obstetric trauma - vaginal delivery with instrument	115	10	7.8	87.0	67.5	128.9
Obstetric trauma - vaginal delivery without instrument	706	20	20.5	28.3	29.1	97.4
Postoperative haemorrhage or haematoma	11789	2	4.3	0.2	0.4	46.3
Postoperative physiologic and metabolic derangement	10188	2	1.7	0.2	0.2	115.5
Postoperative pulmonary embolism or deep vein thrombosis	11879	39	30.5	3.3	2.6	127.7
Postoperative respiratory failure	9326	8	8.5	0.9	0.9	94.1
Postoperative sepsis	141	1	2.1	7.1	15.1	47.0
Postoperative wound dehiscence	369	0	0.3	0	0.8	0.0

4.0 CODING

4.1 Depth of coding

The DCH depth of patient coding for Charlson Co-morbidities has improved from one of the lowest four in the UK and is now around the mean value of all UK Trusts. As a result the Trust's expected death rate had been rising, although COVID has upset the data from March 2020 since COVID +ve patients are excluded from national SHMI data and overall admission fell significantly. The graph below plots Observed (actual) deaths and Expected (calculated from coding) deaths against rolling 12 month time points. Were the two lines to meet, then SHMI = 1.00



5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

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

6.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 18 new Coroner's inquests being opened in the period October 2020 – December 2020. All Inquests that were listed in this quarter were adjourned by the Coroner due to CoVID-19 restrictions.

12 other inquests were held during Quarter 3. Five inquests were heard as Documentary hearings, not requiring DCH attendance. One was attended at Court as this was the clinician's preference. Six required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 50 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. Five pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings, an increasing number of which will be attended virtually. The virtual court room set up within Trust Headquarters appears to be working well, and Ms Mandy Ford (DCH) liaises with the coroner's officer to improve the technology and its use.

8.0 LEARNING FROM CLAIMS

No new data this quarter. See appendix 3 in previous Q2 report

9.0 SUMMARY

SHMI has fallen into the expected range, with evidence of a clear trend to improvement over the past 12 months. No other metrics of in-patient care suggest that excess mortality is occurring at DCH, and much of the national data suggests better than average mortality.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths continue to improve.

Meeting Title:	Board of Directors Part One
Date of Meeting:	31 March 2021
Document Title:	**2020 National Staff Survey Findings**
Responsible Director:	Patricia Miller, CEO
Author:	Julie Barber, Head of OD

Confidentiality:	No (Staff Survey Results published on 12th March 2021)
Publishable under FOI?	**Yes**

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People & Culture Committee	22nd March 2021	Noted and actions recommended to Board.

Purpose of the Paper	This report provides a high level analysis of the overall findings of the 2020 staff survey, identifies individual areas of concern and considers the implications for employee engagement going forward. We have now agreed a timeline of interventions which are outlined in this report along with timescales for delivery.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The national staff survey was undertaken between September and December 2020. A full census survey was undertaken, with a 46% response rate which is 1% above average for Acute Trusts in England (45%). The questionnaire content is agreed nationally and normally covers 11 themes relating to the working environment and staff experience within the workplace. For 2020, the theme of 'Quality of Appraisal' has not been included as part of a national agreement to suspend normal expectations around appraisal, so only 10 themes are reported on. The Trust received higher scores than the average for Acute Trusts in 6 of the 10 themes and equalled the average for the other 4. 9 out of 10 theme areas in 2020 showed no statistically significant change from 2019. However, the theme of Equality, Diversity & Inclusivity was reported as having a statistically significant lower score in 2020, but at 9.2 was still very slightly above the average for Acute Trusts (9.1). This downward trend was anticipated as we have just started a programme of work on EDI and we have been encouraging EM* staff to speak up when they are subjected to racism or discrimination. We have evidence that supports the need to significantly improve inclusive practices at the Trust. The range of interventions and activities outlined within the report will be integral to shifting the culture and embedding inclusivity in all of our activities across the Trust and must therefore be prioritised in order to progress the EDI, wellbeing and staff engagement agendas. **In accordance with latest UK Government guidelines, the terms BAME*							

	(Black, Asian and minority ethnic) or BME (Black and minority ethnic) within this report have been replaced with EM (ethnic minorities). The Dorset System has agreed to refer to staff from EM as 'staff from minority communities'.
Action recommended	The Board is asked to: 1. **NOTE** the content of the report 2. **APPROVE** the actions identified.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	Y	Specific implications relating to the contents of the action plan (cost of specialist EDI consultant for design and initial delivery of key initiatives)
Impacts Strategic Objectives?	Y	Staff feedback received through the national staff survey provides a source of data to inform improvements to leadership and management practices and changes to the working environment. Research suggests that staff engagement, involvement and wellbeing have direct and positive impacts upon the delivery of the Trust's strategic objectives and the delivery of quality patient care.
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	The national staff survey results are used to gauge staff experience within the Trust and will strengthen the Trust's assurance to the CQC and assure that the trust can achieve an "outstanding" status for the Well-Led Domain
Impacts Social Value ambitions?	Y	Recognised as a Good Employer, ensuring employees have a positive & fulfilling experience.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

2020 National Staff Survey Findings

Executive Summary

The national staff survey was undertaken between September and December 2020. A full census survey was undertaken, with a 46% response rate which is 1% above average for Acute Trusts in England (45%).

The questionnaire content is agreed nationally and normally covers 11 themes relating to the working environment and staff experience within the workplace. For 2020, the theme of 'Quality of Appraisal' has not been included as part of a national agreement to suspend normal expectations around appraisal, so only 10 themes are reported on.

9 out of 10 theme areas in 2020 showed no statistically significant change from 2019. However, the theme of Equality, Diversity & Inclusivity was reported as having a statistically significant lower score in 2020, but at 9.2 was still very slightly above the average for Acute Trusts (which is 9.1).

The recently published WRES report places DCH amongst the worst Acute Trusts in the country for bullying and harassment of EM* staff. We were expecting this for two reasons. We have just started a programme of work on EDI and we have been encouraging EM* staff to speak up when they are subjected to racism or discrimination.

The results of the 2020 WRES Report are being reported as a separate item at this Committee.

This report provides a high level analysis of the overall findings of the 2020 staff survey, identifies individual areas of concern and considers the implications for employee engagement going forward. We have now agreed a timeline of interventions which are outlined in this report along with timescales for delivery.

**In accordance with latest UK Government guidelines, the terms BAME (Black, Asian and minority ethnic) or BME (Black and minority ethnic) within this report have been replaced with EM (ethnic minorities). The Dorset System has agreed to refer to staff from EM as 'staff from minority communities'.*

1. Introduction

The Trust recognises the important link between staff engagement and improved patient care. Understanding how staff experience their work environment is critical to the success of any organisation and the NHS National Staff Survey provides an important insight into how our staff experience work at DCH.

This 'soft' data is one way our people can communicate opinions and views about working here at the Trust. It provides an anonymous forum for staff to give their views on issues which they may not feel comfortable or safe to air via other routes. As the Trust

undertakes focused interventions on culture, inclusion and leadership, we would expect to see the impact of these in the responses our people give.

As with any survey, the most critical aspect of the process is not just about reviewing the results but being clear about where we want to be as an organisation and what needs to be done differently to ensure we are.

The Committee is asked to note the content of the report and approve the actions outlined.

2. Methodology

The guiding framework for the Trust's staff survey is agreed at national level and the process is administered by external specialists Quality Health. A full census staff survey was used.

The survey contains over 100 questions concerned with staff perceptions of their job, their managers, their health, wellbeing and safety at work, their personal development and their organisation. The questionnaire content is agreed nationally and normally covers 11 themes relating to the working environment and staff experience within the workplace. **For 2020, the theme of 'Quality of Appraisal' has not been included as part of a national agreement to suspend normal expectations around appraisal, so only 10 themes are reported on.**

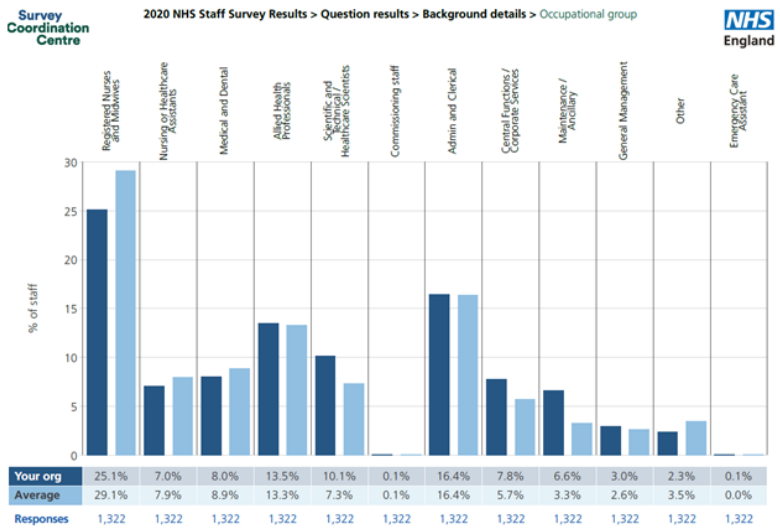
The themes include the four staff pledges from the NHS Constitution and three additional themes of equality and diversity, errors and incidents and patient experience measures. A number of the survey questions provides key data for measuring progress on equality and inform four indicators of the Workforce Race and Disability Equality Standards.

3. Response rate & Occupational Groups

1,358 completed responses were received giving a response rate of 46.4%. This was an increase of 3.5% (1.5 percentage points) from 2019, taking the Trust to just above the average response rate for 2020. This follows a dip in 2019 of 4.4% from 2018 which took the Trust below the average response rate for acute trusts nationally. The overall trend in response rate is down since 2016, with a small upturn this year. The previously below-average response rate is something that was identified for action in the 2019 report, with action plans to increase this having been limited by the Covid-19 pandemic. This will be a vital part of the action plan for 2021. Although this year's improvement is small, given the difficult year staff have faced and the previous trend, this enables us to be optimistic that a significant increase in response rates is possible with targeted actions in 2021.

Response rate percentages for most occupational groups remain very similar to 2019, with Registered Nurses and Midwives, HCAs and Medical and Dental all below national average. Completion rates for Allied Health Professionals and Scientific/Technical Healthcare Scientists have both seen an increase taking them above the national average (see **Graph 1**).

Graph 1: Response rate by Occupational Group 2020



4. Demographics

Of the staff who completed the survey, the demographics were as follows:

- 76% are female – in line with the national average.
- 37% are aged between 51 and 65 years – 10.5 % higher than the national average.
- 24.5% have a disability – a 16% increase on 2019 and 23% higher than the national average
- 89.5% are heterosexual, 3.8% are gay, lesbian, bisexual or ‘other’, 6.8% ‘prefer not to say’ (which is the same as the national average).
- 91.5% are white, 1.7% mixed ethnic background, 5.7% Asian/Asian British, 0.7% Black/African/Caribbean/Black British, and 0.2% other ethnic group.
- The percentage of those with caring responsibilities for adults or children is lower than the national average.

- The percentage of staff with a religion other than Christianity (4.4%) is 33% lower than the national average, with the percentage of Christians (50%) in line with national average, and those with no religion make up 39.7%.

5. Findings

The results from this survey have previously been considered in the context of: (a) internal year-on-year comparison and (b) external comparison with the other acute (non-specialist) trusts in England. We are aware that results for some indicators are not where they should be right across the NHS, particularly those relating to the wellbeing of colleagues from ethnic minority groups and those with long term health conditions and disabilities. We acknowledge that we must also consider ways of addressing these inequalities as we move forward.

Table 1 compares DCH 2020 theme score results with those of 2019.

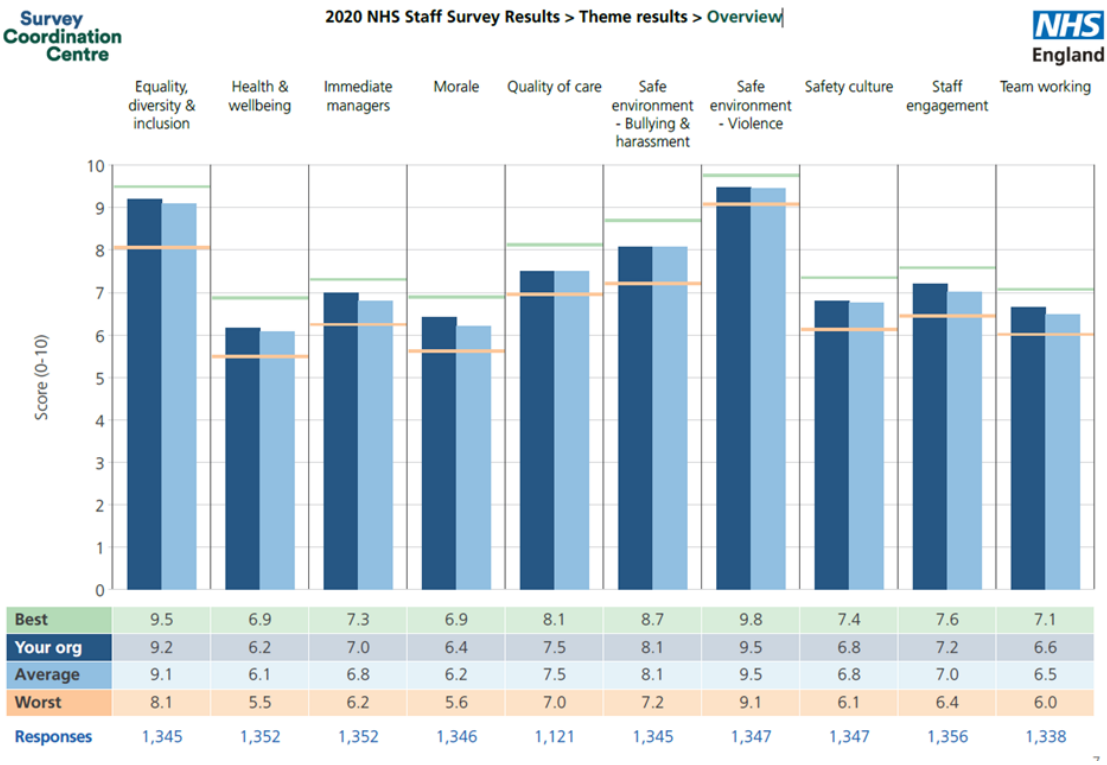
All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. **Of the 10 themes, only one has seen a statistically significant change for 2020. This is Equality, Diversity and Inclusion, which has seen a 0.2 drop in score from 2019.**

Table 1

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.4**	1215	**9.2**	1345	↓
Health & wellbeing	**6.1**	1220	**6.2**	1352	Not significant
Immediate managers †	**7.1**	1222	**7.0**	1352	Not significant
Morale	**6.4**	1208	**6.4**	1346	Not significant
Quality of care	**7.4**	1018	**7.5**	1121	Not significant
Safe environment - Bullying & harassment	**8.1**	1216	**8.1**	1345	Not significant
Safe environment - Violence	**9.5**	1214	**9.5**	1347	Not significant
Safety culture	**6.8**	1215	**6.8**	1347	Not significant
Staff engagement	**7.2**	1232	**7.2**	1356	Not significant
Team working	**6.8**	1216	**6.6**	1338	Not significant

When the results are compared against other acute trusts, DCH equals the national average for four themes, and is above average for the other six, as illustrated in **Graph 2.** However, the drop in score for Equality, Diversity and Inclusion has brought the Trust from 'Best' in 2019 to nearer the average score this year.

Graph 2: Overview of Theme Results



6. Results by Theme

6.1 Equality, Diversity & Inclusion (EDI)

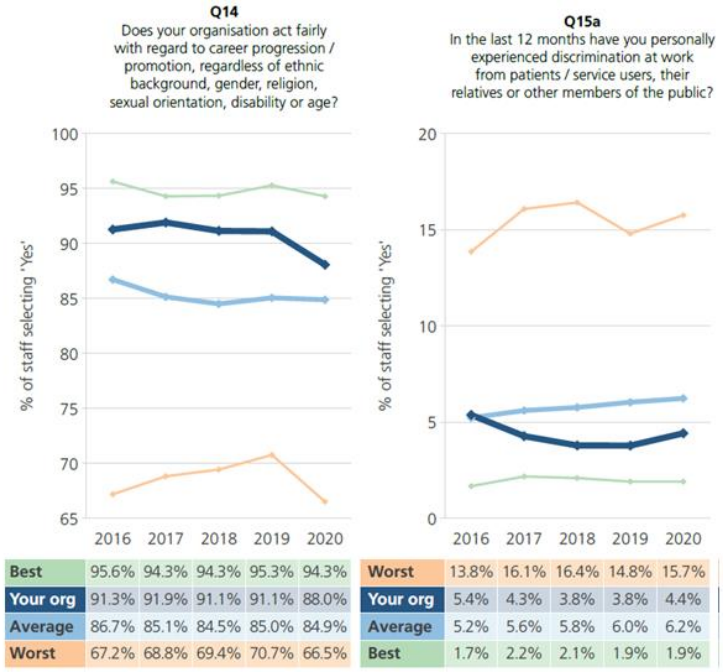
This theme includes four questions. For Q14 and 15a, we remain above the national average (see **Graph 3**); for Q15b and Q26b (see **Graph 4**), DCH has dropped below average, having been above for the previous four years. Scores for all questions in this theme are worse than 2019. **EDI is the only theme where there is a statistically significant negative difference to 2019.**

Whilst 742 respondents to the survey felt the **organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age** (Q.14), more than half that number responded 'don't know', indicating a potential lack of awareness/understanding rather than being able to comment on unfair practices.

48 staff felt adequate adjustments had not been made to enable them to carry out their work effectively (Q.26b), potentially putting them at a disadvantage. Culture Review feedback indicates that staff sense of belonging is adversely affected by subtle comments around vulnerabilities e.g. mental health needs & disabilities, leaving some staff feeling

like the ‘poor relations’. Assumptions, biases and stereotyping were all cited as barriers to being heard.

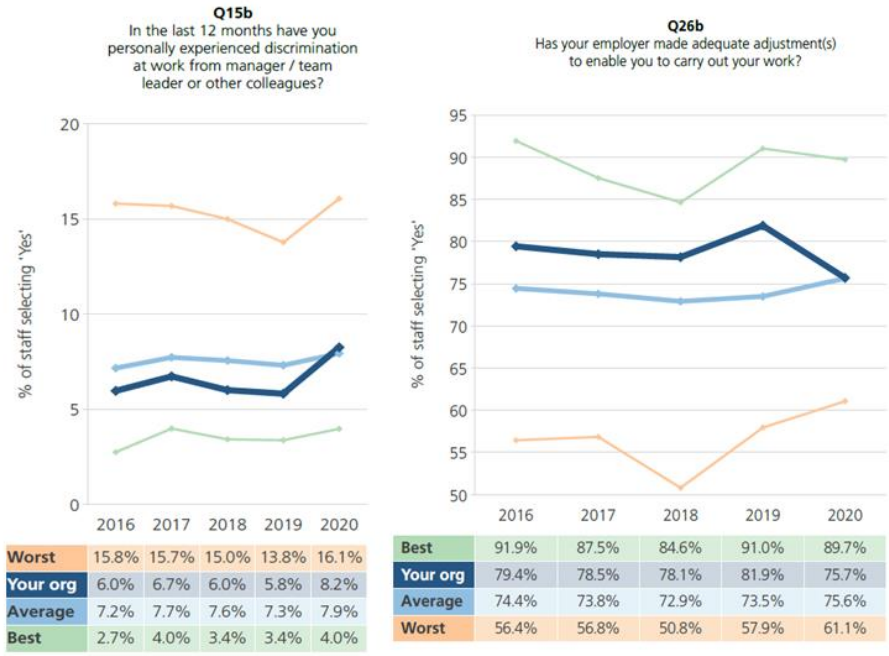
Graph 3: Q.14 & 15a



	2016	2017	2018	2019	2020
Best	95.6%	94.3%	94.3%	95.3%	94.3%
Your org	91.3%	91.9%	91.1%	91.1%	88.0%
Average	86.7%	85.1%	84.5%	85.0%	84.9%
Worst	67.2%	68.8%	69.4%	70.7%	66.5%

	2016	2017	2018	2019	2020
Worst	13.8%	16.1%	16.4%	14.8%	15.7%
Your org	5.4%	4.3%	3.8%	3.8%	4.4%
Average	5.2%	5.6%	5.8%	6.0%	6.2%
Best	1.7%	2.2%	2.1%	1.9%	1.9%

Graph 4: Q.15b & 26b



	2016	2017	2018	2019	2020
Worst	15.8%	15.7%	15.0%	13.8%	16.1%
Your org	6.0%	6.7%	6.0%	5.8%	8.2%
Average	7.2%	7.7%	7.6%	7.3%	7.9%
Best	2.7%	4.0%	3.4%	3.4%	4.0%

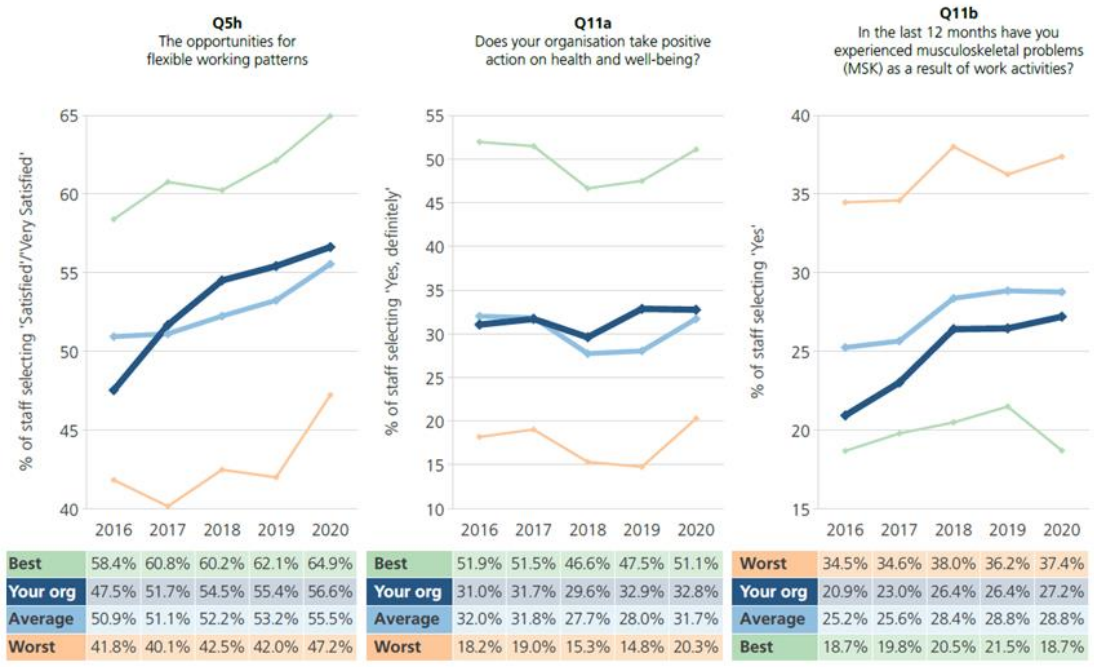
	2016	2017	2018	2019	2020
Best	91.9%	87.5%	84.6%	91.0%	89.7%
Your org	79.4%	78.5%	78.1%	81.9%	75.7%
Average	74.4%	73.8%	72.9%	73.5%	75.6%
Worst	56.4%	56.8%	50.8%	57.9%	61.1%

6.2 Health & Wellbeing

Of the five questions making up this theme, DCH scores above national average for Q5h, Q11a, Q11b and Q11c (see **Graphs 5 & 6**) However, there has been a noticeable downturn in Q11d (see **Graph 6**). This is seen nationally, and may be expected due to Covid-19. **However the increase in percentage of staff feeling unwell as a result of workplace stress at DCH is steeper than average**.

33% of staff definitely felt that the organisation takes positive action on health & wellbeing (Q.11a), with a further 59% saying yes, to some extent. This is exactly the same result as last year and mirrors the national picture, but demonstrates that there is some way to go in terms of providing appropriate wellbeing support across the Trust.

Graph 5: Q.5h, 11a & 11b

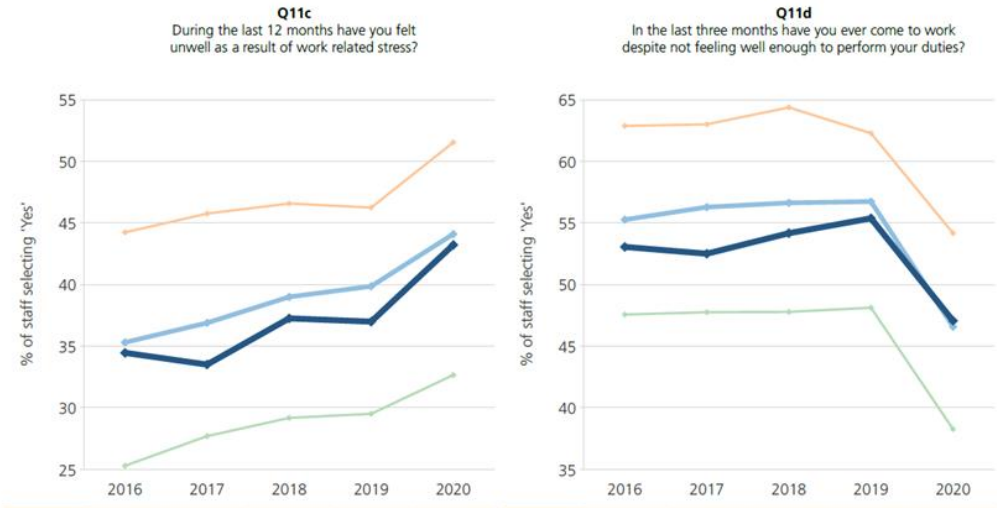


Best	58.4%	60.8%	60.2%	62.1%	64.9%
Your org	47.5%	51.7%	54.5%	55.4%	56.6%
Average	50.9%	51.1%	52.2%	53.2%	55.5%
Worst	41.8%	40.1%	42.5%	42.0%	47.2%

Best	51.9%	51.5%	46.6%	47.5%	51.1%
Your org	31.0%	31.7%	29.6%	32.9%	32.8%
Average	32.0%	31.8%	27.7%	28.0%	31.7%
Worst	18.2%	19.0%	15.3%	14.8%	20.3%

Worst	34.5%	34.6%	38.0%	36.2%	37.4%
Your org	20.9%	23.0%	26.4%	26.4%	27.2%
Average	25.2%	25.6%	28.4%	28.8%	28.8%
Best	18.7%	19.8%	20.5%	21.5%	18.7%

Graph 6: Q. 11c & 11d



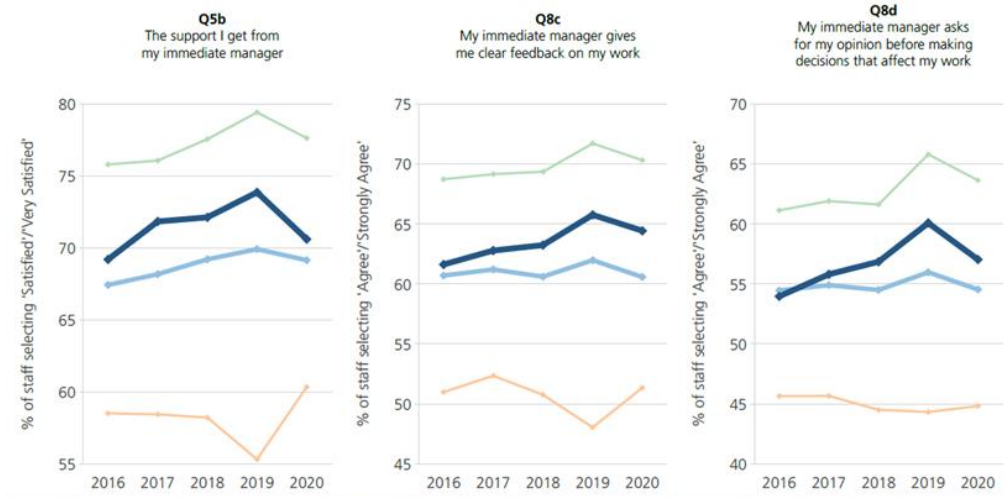
	2016	2017	2018	2019	2020
Worst	44.2%	45.8%	46.6%	46.2%	51.5%
Your org	34.5%	33.5%	37.2%	37.0%	43.2%
Average	35.3%	36.9%	39.0%	39.9%	44.1%
Best	25.3%	27.7%	29.2%	29.5%	32.6%

	2016	2017	2018	2019	2020
Worst	62.9%	63.0%	64.4%	62.3%	54.2%
Your org	53.0%	52.5%	54.2%	55.4%	47.1%
Average	55.3%	56.3%	56.6%	56.7%	46.6%
Best	47.6%	47.7%	47.8%	48.1%	38.3%

6.3 Immediate Managers

Of the five questions making up this theme, DCH continues to score higher than the national average in all categories but there has been a downward trend for all five questions, which may be linked to the impact of Covid.

Graph 7: Q.5b, 8c & 8d

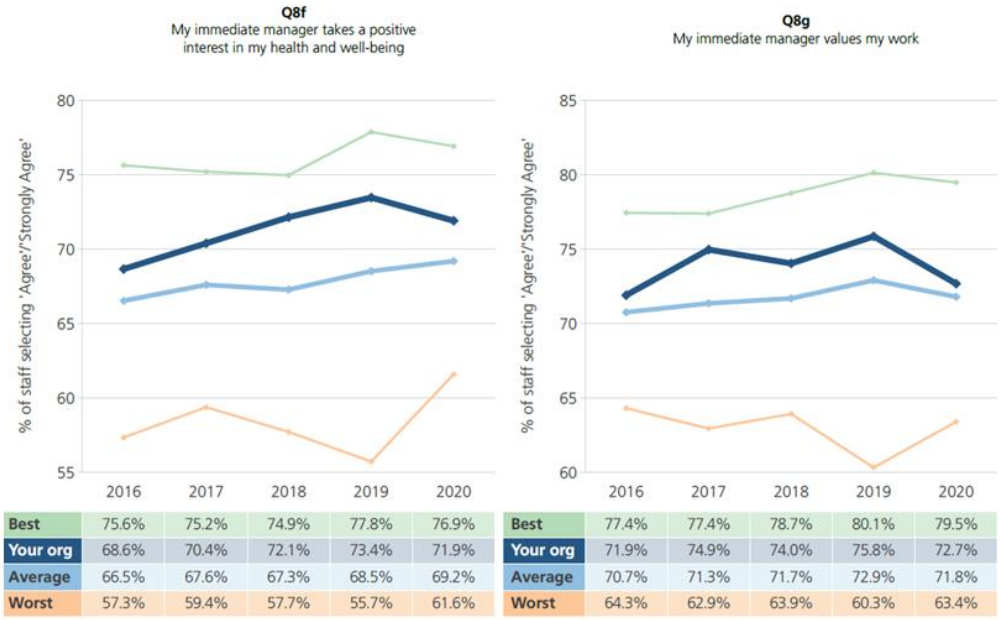


	2016	2017	2018	2019	2020
Best	75.8%	76.1%	77.5%	79.4%	77.6%
Your org	69.2%	71.8%	72.1%	73.8%	70.6%
Average	67.4%	68.2%	69.2%	69.9%	69.1%
Worst	58.5%	58.4%	58.2%	55.3%	60.3%

	2016	2017	2018	2019	2020
Best	68.7%	69.1%	69.3%	71.7%	70.3%
Your org	61.6%	62.8%	63.2%	65.7%	64.4%
Average	60.7%	61.2%	60.6%	62.0%	60.6%
Worst	51.0%	52.3%	50.8%	48.0%	51.3%

	2016	2017	2018	2019	2020
Best	61.1%	61.9%	61.6%	65.8%	63.6%
Your org	54.0%	55.8%	56.8%	60.1%	57.0%
Average	54.4%	54.9%	54.5%	56.0%	54.5%
Worst	45.6%	45.7%	44.5%	44.3%	44.8%

Graph 8: Q.8f & 8g



	2016	2017	2018	2019	2020
Best	75.6%	75.2%	74.9%	77.8%	76.9%
Your org	68.6%	70.4%	72.1%	73.4%	71.9%
Average	66.5%	67.6%	67.3%	68.5%	69.2%
Worst	57.3%	59.4%	57.7%	55.7%	61.6%

	2016	2017	2018	2019	2020
Best	77.4%	77.4%	78.7%	80.1%	79.5%
Your org	71.9%	74.9%	74.0%	75.8%	72.7%
Average	70.7%	71.3%	71.7%	72.9%	71.8%
Worst	64.3%	62.9%	63.9%	60.3%	63.4%

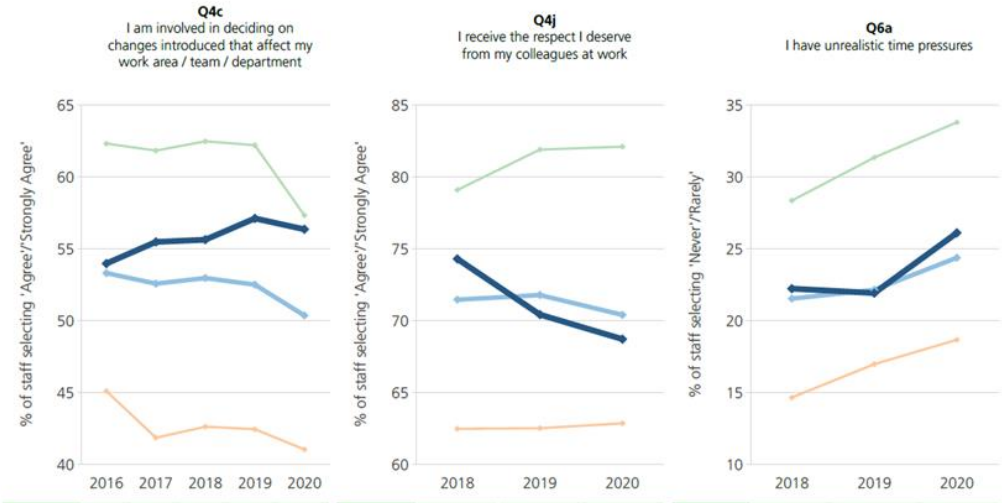
6.4 Morale

There are some upwards and downward trends in respect of morale. Most questions score significantly higher than the national average, but often the national average is not good. 71% of staff felt **their immediate line manager encourages them at work** (Q.8a) and 70% feel they get the respect they deserve from colleagues, leaving nearly one-third of staff disagreeing or having no opinion. (Q.4j). More than half staff **experience strained relationships either sometimes, often or always** (Q.6c)

A quarter of staff said that they **often think about leaving the organisation** (Q.19a) and 15% of staff who say they **will probably look for a job in a new organisation within the next 12 months** (Q.19b) – that equates to 200 staff who may be actively looking for other work, 135 0f which say that they **will leave as soon as the find another job** (Q.19c).

Discontent with the organisation is slightly lower than the national average, with 14% of staff saying they would **want to move to a job in a different NHS Trust/organisation**.

Graph 9: Q. 4c, 4j & 6a

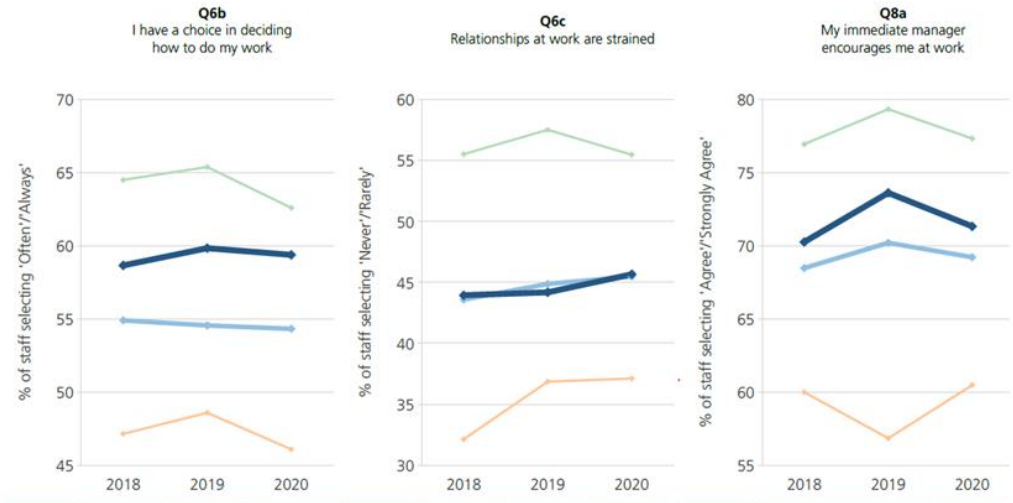


	2016	2017	2018	2019	2020
Best	62.3%	61.8%	62.5%	62.2%	57.3%
Your org	54.0%	55.5%	55.6%	57.1%	56.3%
Average	53.3%	52.6%	52.9%	52.5%	50.3%
Worst	45.1%	41.8%	42.6%	42.4%	41.0%

	2018	2019	2020
Best	79.1%	81.9%	82.1%
Your org	74.3%	70.4%	68.7%
Average	71.4%	71.8%	70.4%
Worst	62.5%	62.5%	62.8%

	2018	2019	2020
Best	28.3%	31.3%	33.8%
Your org	22.2%	21.9%	26.1%
Average	21.5%	22.1%	24.4%
Worst	14.6%	17.0%	18.6%

Graph 10:Q.6b, 6c & 8a

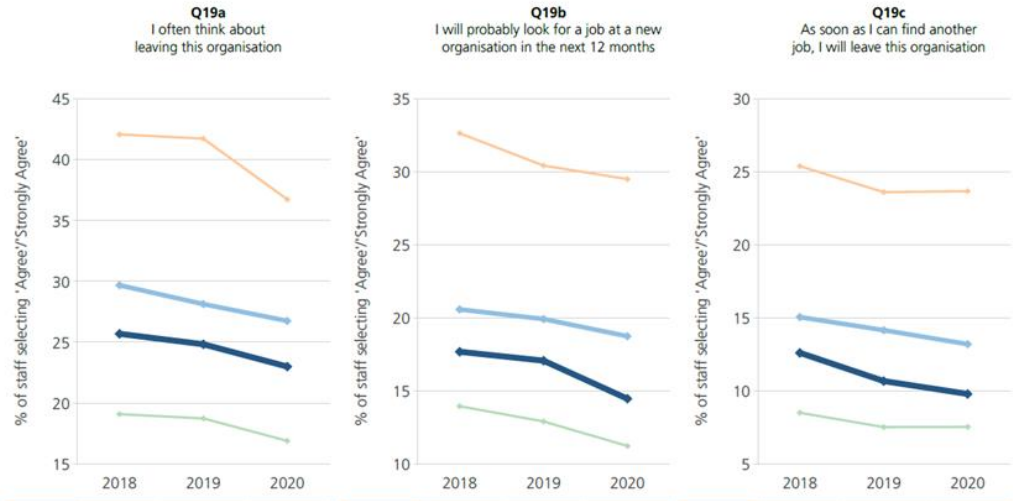


	2018	2019	2020
Best	64.5%	65.4%	62.6%
Your org	58.6%	59.8%	59.4%
Average	54.9%	54.5%	54.3%
Worst	47.1%	48.6%	46.1%

	2018	2019	2020
Best	55.5%	57.5%	55.5%
Your org	43.9%	44.2%	45.6%
Average	43.6%	44.9%	45.5%
Worst	32.1%	36.9%	37.1%

	2018	2019	2020
Best	76.9%	79.3%	77.3%
Your org	70.2%	73.6%	71.3%
Average	68.5%	70.2%	69.2%
Worst	60.0%	56.8%	60.5%

Graph 11: Q.19a, 19b & 19c



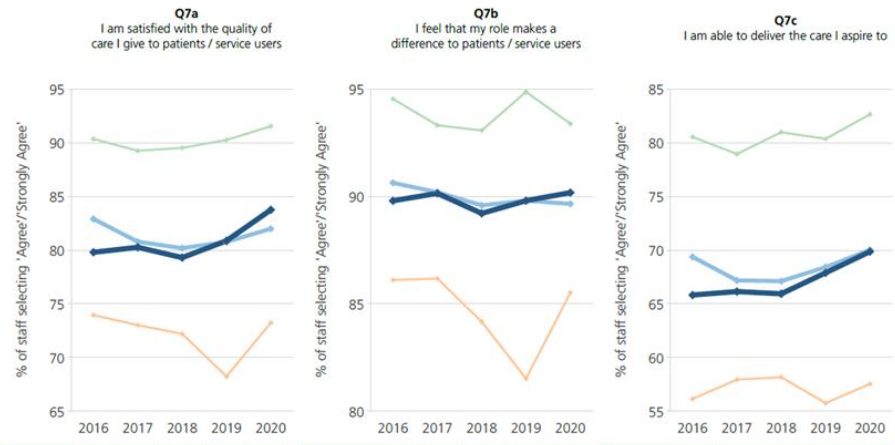
	Q19a			Q19b			Q19c		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Worst	42.0%	41.7%	36.7%	32.6%	30.4%	29.5%	25.4%	23.6%	23.7%
Your org	25.7%	24.8%	23.0%	17.7%	17.1%	14.5%	12.6%	10.7%	9.8%
Average	29.7%	28.1%	26.7%	20.6%	19.9%	18.7%	15.0%	14.1%	13.2%
Best	19.1%	18.7%	16.9%	13.9%	12.9%	11.2%	8.5%	7.5%	7.5%

6.5 Quality of Care

The three questions for this theme score higher or equal the national average.

Whilst 90% of staff felt that their role made a difference to patients/service users (Q.7b), only 69% felt they were able to deliver the care they aspire to (Q.7c) but despite this, 83% said they were satisfied with the quality of care they gave (Q.7a) and 80% said that **if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation** (Staff Engagement Q.18d) – 5% higher than the national average.

Graph 12: Q.7a, 7b & 7c

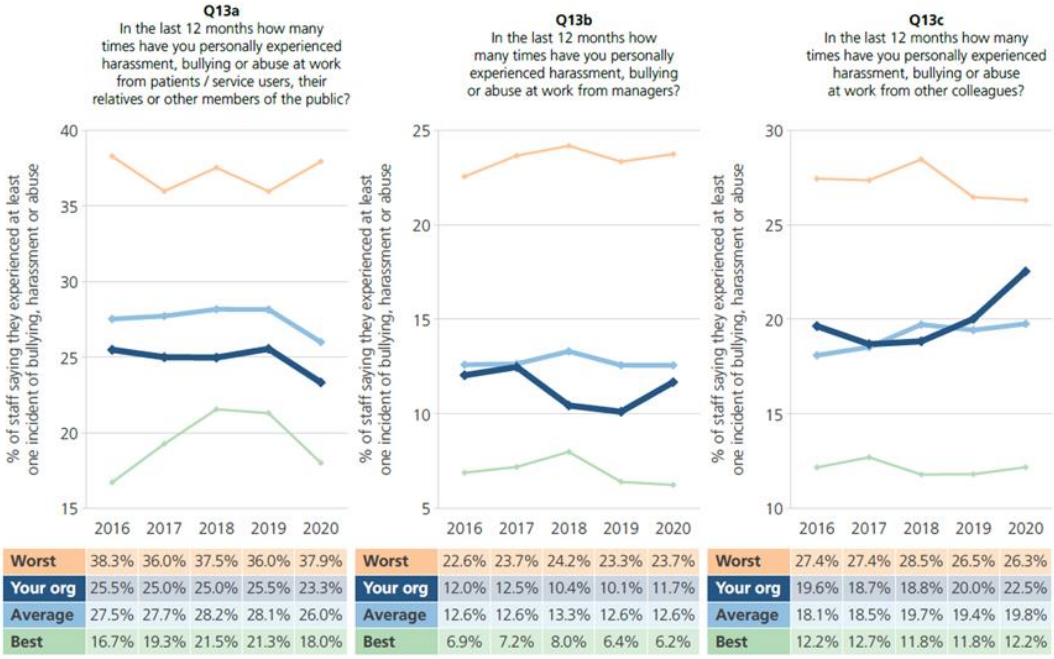


	Q7a					Q7b					Q7c				
	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020
Best	90.4%	89.3%	89.5%	90.3%	91.6%	94.5%	93.3%	93.1%	94.9%	93.4%	80.6%	79.0%	81.0%	80.4%	82.7%
Your org	79.8%	80.3%	79.3%	80.9%	83.8%	89.8%	90.1%	89.2%	89.8%	90.2%	65.8%	66.1%	65.9%	67.9%	69.9%
Average	82.9%	80.8%	80.2%	80.8%	82.0%	90.6%	90.2%	89.6%	89.8%	89.7%	69.4%	67.2%	67.1%	68.4%	70.0%
Worst	73.9%	73.0%	72.2%	68.2%	73.2%	86.1%	86.2%	84.2%	81.5%	85.5%	56.1%	57.9%	58.2%	55.7%	57.5%

6.6 Safe environment – Bullying & harassment

Over a fifth of our staff report experiencing harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public (Q.13a) or other colleagues (Q.13c). 13% experience this behaviour from their managers (Q.13b). This equates to 156 staff experiencing some form of harassment or bullying from their manager, rising to 296 staff experiencing this from colleagues.

Graph 13: Q.13a, 13b & 13c



	2016	2017	2018	2019	2020
Worst	38.3%	36.0%	37.5%	36.0%	37.9%
Your org	25.5%	25.0%	25.0%	25.5%	23.3%
Average	27.5%	27.7%	28.2%	28.1%	26.0%
Best	16.7%	19.3%	21.5%	21.3%	18.0%

	2016	2017	2018	2019	2020
Worst	22.6%	23.7%	24.2%	23.3%	23.7%
Your org	12.0%	12.5%	10.4%	10.1%	11.7%
Average	12.6%	12.6%	13.3%	12.6%	12.6%
Best	6.9%	7.2%	8.0%	6.4%	6.2%

	2016	2017	2018	2019	2020
Worst	27.4%	27.4%	28.5%	26.5%	26.3%
Your org	19.6%	18.7%	18.8%	20.0%	22.5%
Average	18.1%	18.5%	19.7%	19.4%	19.8%
Best	12.2%	12.7%	11.8%	11.8%	12.2%

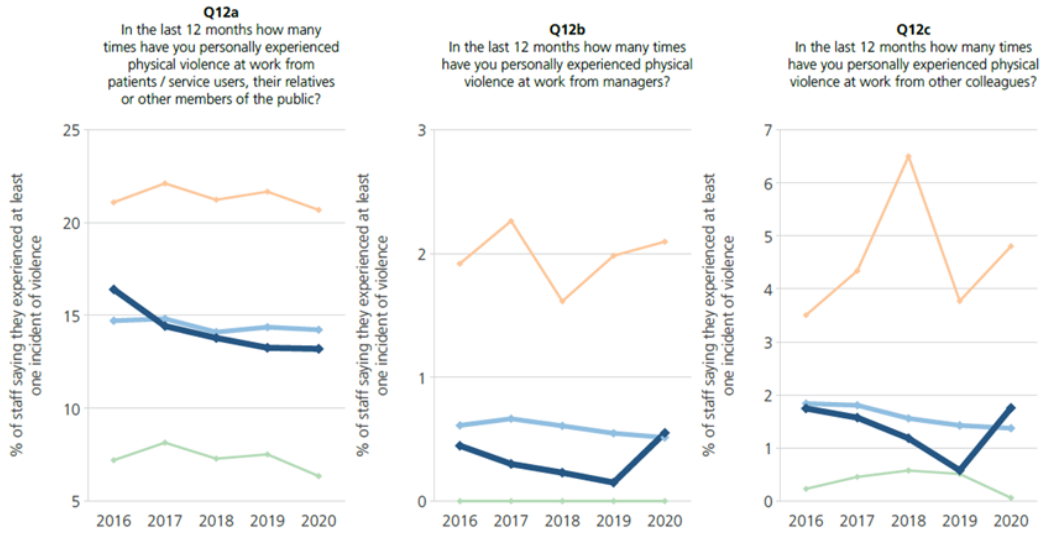
6.7 Safe environment – Violence

22 staff experienced **physical violence from colleagues** (Q.12c), 7 from **managers** (Q.12b) and 164 reporting this experience from **patients/service users, their relatives or other members of the public**.

41% of staff said that **the last time they experienced physical violence at work, it went unreported** (Health, Wellbeing & Safety - Q.12d).

The under-reporting of physical violence (and verbal harassment) is an area to be improved (see 'Plans moving forward' in Section 10 of this report).

Graph 14: Q.12a, 12b & 12c



	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your org	16.4%	14.4%	13.8%	13.3%	13.2%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

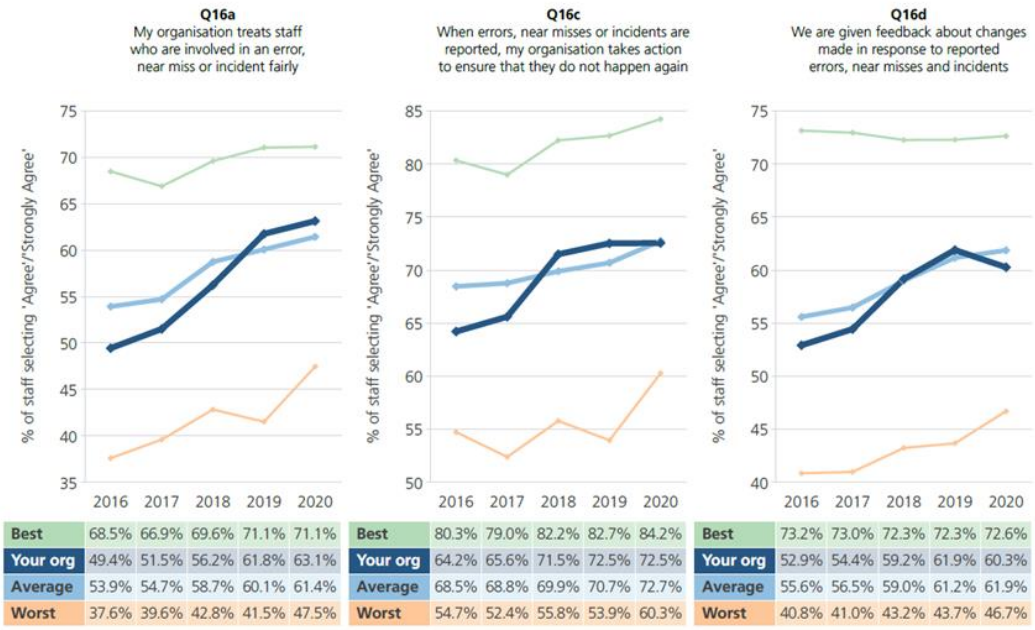
	2016	2017	2018	2019	2020
Worst	1.9%	2.3%	1.6%	2.0%	2.1%
Your org	0.4%	0.3%	0.2%	0.1%	0.6%
Average	0.6%	0.7%	0.6%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

	2016	2017	2018	2019	2020
Worst	3.5%	4.3%	6.5%	3.8%	4.8%
Your org	1.7%	1.6%	1.2%	0.6%	1.8%
Average	1.8%	1.8%	1.6%	1.4%	1.4%
Best	0.2%	0.5%	0.6%	0.5%	0.1%

6.8 Safety Culture

The six questions here had mixed scores, some with upward trajectories whilst some were opposite. 63% of staff agreed that the Trust treats staff who are involved in an error, near miss or incident fairly (Q.16a), just 1% above the national comparator. Whilst 89% of staff state that the Trust encourages them to report errors, near misses or incidents (Q.16b), the lower perception of fairness being applied may discourage some staff to do so. Only 60% of staff say they are given feedback about changes in response to reported errors, near misses and incidents (Q.16d). Whilst 71% say they would feel secure raising concerns about unsafe clinical practice (Q.17b) only 60% are confident that the Trust would address their concern.

Graph 15: Q.16a, 16c & 16d

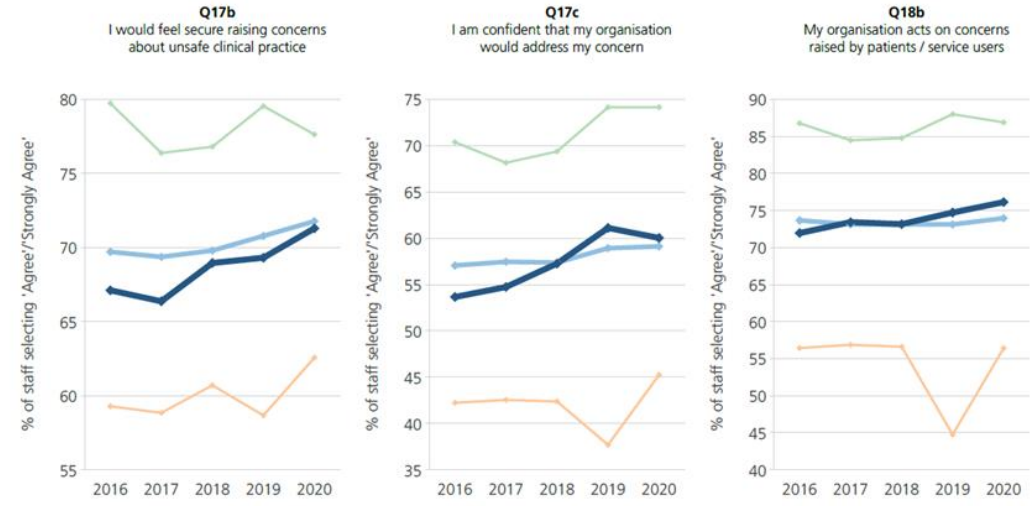


	2016	2017	2018	2019	2020
Best	68.5%	66.9%	69.6%	71.1%	71.1%
Your org	49.4%	51.5%	56.2%	61.8%	63.1%
Average	53.9%	54.7%	58.7%	60.1%	61.4%
Worst	37.6%	39.6%	42.8%	41.5%	47.5%

	2016	2017	2018	2019	2020
Best	80.3%	79.0%	82.2%	82.7%	84.2%
Your org	64.2%	65.6%	71.5%	72.5%	72.5%
Average	68.5%	68.8%	69.9%	70.7%	72.7%
Worst	54.7%	52.4%	55.8%	53.9%	60.3%

	2016	2017	2018	2019	2020
Best	73.2%	73.0%	72.3%	72.3%	72.6%
Your org	52.9%	54.4%	59.2%	61.9%	60.3%
Average	55.6%	56.5%	59.0%	61.2%	61.9%
Worst	40.8%	41.0%	43.2%	43.7%	46.7%

Graph 16: Q.17b, 17c & 18b

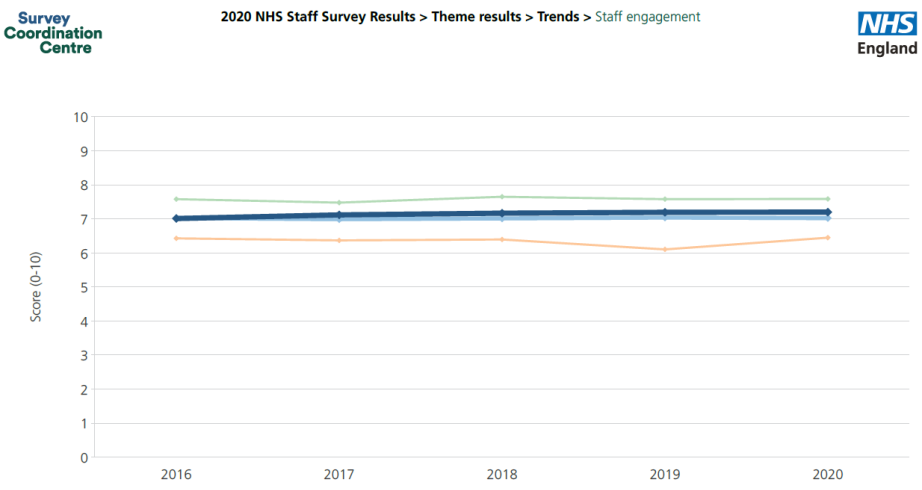


6.9 Staff engagement

The staff engagement index is made up of nine statements on three themes: 'Motivation', 'Ability to make contribute to improvements', and 'Recommendation of the organisation as a place to work/receive treatment'.

As indicated in **Graph 17**, DCH's overall engagement score for 2020 is 7.2. This score remains the same as in the two previous years and is above the national benchmark of 7.0. There are, however, some notable changes on the scoring of individual nine statements on previous years.

Graph 17 – Overall engagement scores



	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
Your org	7.0	7.1	7.2	7.2	7.2
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.4	6.4	6.1	6.4
Responses	1,376	1,321	1,316	1,232	1,356

6.9.1 Motivation

A national drop has been seen in how staff have scored enthusiasm about their job, and how quickly time passes when they are at work. This is reflected here at DCH. However, there has been an improvement in the DCH score and **a continuing upward trend** in DCH staff response to **'I look forward to going to work'** – this is despite a drop to the national average.

Graph 18: Q.2a, 2b & 2c

	2016	2017	2018	2019	2020
Best	67.9%	66.6%	67.6%	68.7%	67.8%
Your org	57.4%	59.9%	60.0%	61.5%	61.9%
Average	59.9%	58.5%	59.4%	59.4%	58.5%
Worst	49.4%	50.2%	50.6%	47.2%	51.8%

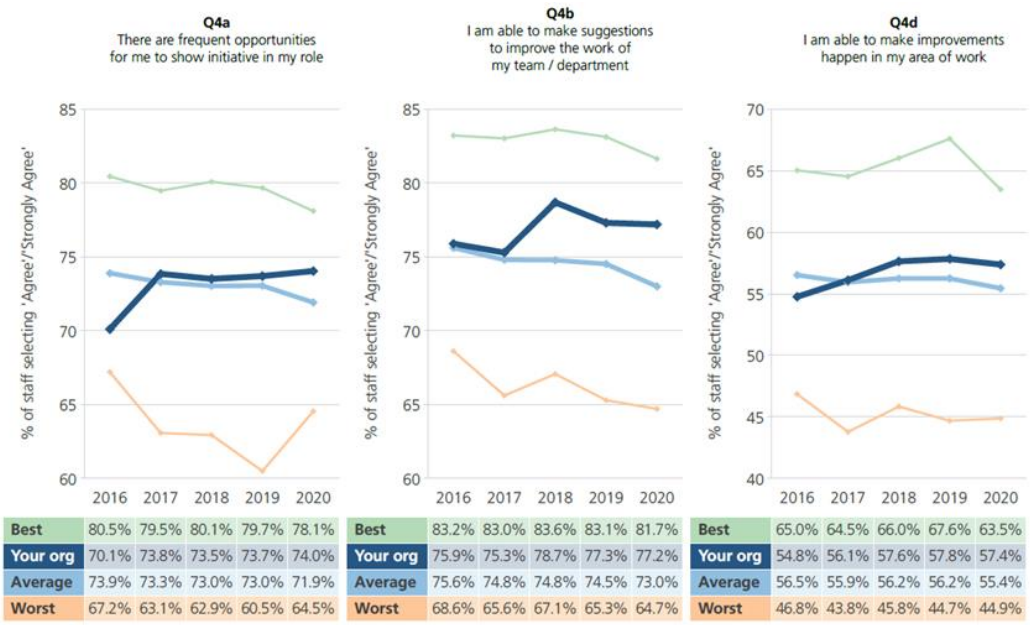
	2016	2017	2018	2019	2020
Best	80.3%	79.2%	82.0%	81.8%	79.7%
Your org	73.0%	74.6%	75.8%	77.5%	76.3%
Average	75.3%	74.1%	74.9%	75.2%	73.1%
Worst	66.2%	68.1%	67.8%	67.4%	68.0%

	2016	2017	2018	2019	2020
Best	84.9%	84.0%	83.4%	82.9%	81.1%
Your org	75.6%	77.4%	76.4%	76.7%	75.7%
Average	78.1%	77.2%	77.2%	77.3%	76.0%
Worst	72.0%	72.2%	72.5%	71.4%	71.4%

6.9.2 Ability to contribute to improvements

74% of staff felt there are **frequent opportunities to show initiative** in their role (Q.4a) and slightly more (77%) felt able to **make suggestions to improve work in their team/department** (Q.4b). Actually making improvements happen, whilst higher than the national average, suggests room for improvement, scoring 57% (Q.4d).

Graph 19: Q.4a, 4b & 4d



	2016	2017	2018	2019	2020
Best	80.5%	79.5%	80.1%	79.7%	78.1%
Your org	70.1%	73.8%	73.5%	73.7%	74.0%
Average	73.9%	73.3%	73.0%	73.0%	71.9%
Worst	67.2%	63.1%	62.9%	60.5%	64.5%

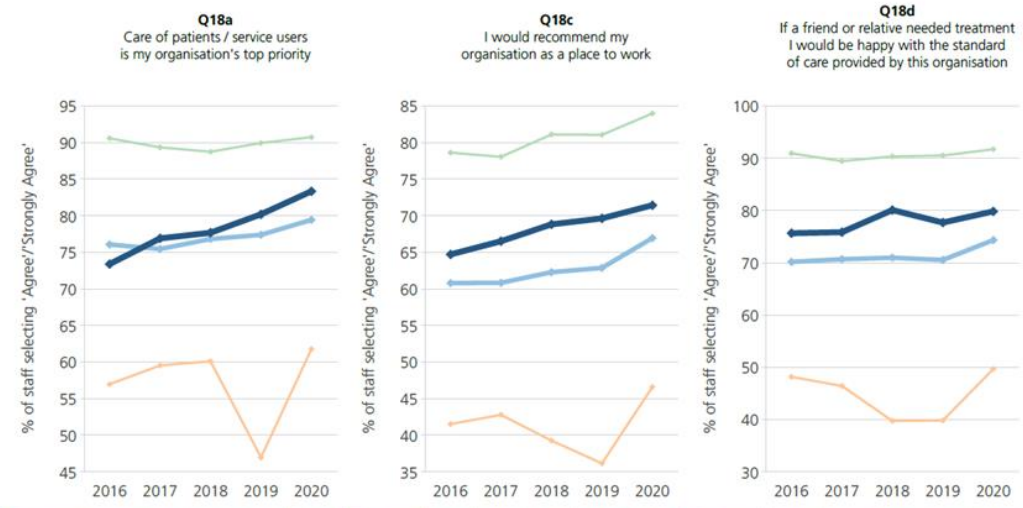
	2016	2017	2018	2019	2020
Best	83.2%	83.0%	83.6%	83.1%	81.7%
Your org	75.9%	75.3%	78.7%	77.3%	77.2%
Average	75.6%	74.8%	74.8%	74.5%	73.0%
Worst	68.6%	65.6%	67.1%	65.3%	64.7%

	2016	2017	2018	2019	2020
Best	65.0%	64.5%	66.0%	67.6%	63.5%
Your org	54.8%	56.1%	57.6%	57.8%	57.4%
Average	56.5%	55.9%	56.2%	56.2%	55.4%
Worst	46.8%	43.8%	45.8%	44.7%	44.9%

6.9.3 Recommendation of the organization as a place to work/receive treatment

Both nationally and here at DCH, **all three scores for 'Recommendation of the organisation as a place to work/receive treatment' have increased** – which is a testament to our staff, and the pride in their organisations across the NHS in this most challenging year.

Graph 20: Q.18a, 18c & 18d



	2016	2017	2018	2019	2020
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	73.4%	76.9%	77.7%	80.2%	83.3%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

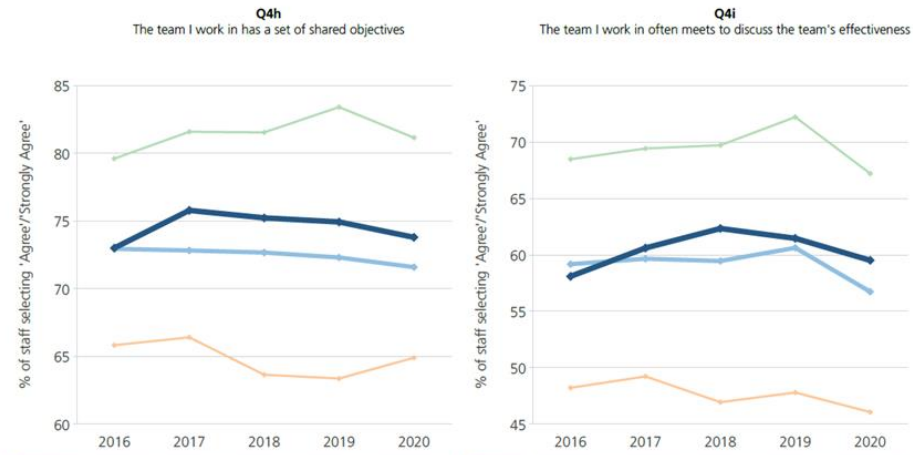
	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	64.7%	66.5%	68.8%	69.6%	71.4%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	75.7%	75.9%	80.1%	77.7%	79.8%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

6.10 Team Working

Whilst the scores for these two questions are slightly above the national average, there is room for improvement. 74% agreed that the team they work in has a **shared set of objectives** (Q.4h) but only 60% of staff agreed that the team they work in often meets to **discuss the team's effectiveness** (Q.4i).

Graph 21: Q.4h & 4i



	2016	2017	2018	2019	2020
Best	79.6%	81.6%	81.6%	83.4%	81.2%
Your org	73.0%	75.8%	75.2%	74.9%	73.8%
Average	72.9%	72.8%	72.7%	72.3%	71.6%
Worst	65.8%	66.4%	63.6%	63.4%	64.9%

	2016	2017	2018	2019	2020
Best	68.5%	69.4%	69.7%	72.2%	67.2%
Your org	58.1%	60.6%	62.3%	61.5%	59.5%
Average	59.2%	59.7%	59.5%	60.6%	56.7%
Worst	48.2%	49.2%	46.9%	47.8%	46.1%

7. Workforce Race Equality Standard (WRES)

For the Staff Survey, EM is defined as those who have recorded their ethnicity in a category other than white. 9% of our respondents' ethnicity was categorised as EM.

Whilst reports of bullying or abuse from patients or relatives has remained fairly static for the last three years (following in an increase in 2018), there has been a significant increase in the percentage of EM staff reporting harassment, bullying or abuse **from colleagues**, following a substantial increase in 2019.

The Trust has worked to encourage our EM staff to feel safe in speaking out against these behaviours. As a report commissioned by NHS Employers in 2016 states:

'Although increases in bullying prevalence should undoubtedly be addressed, we need to be mindful that an increase in reported bullying may reflect a change in culture: changing expectations of the behaviour of colleagues and managers, or a move towards greater openness and willingness to address concerns that were previously ignored or condoned. A measure of employees' trust in the organisation to respond appropriately to such allegations may act as a positive indicator.'

It must be highlighted that although the percentage of minority staff who have been bullied or harassed has increased, ***the percentage of minority staff who would recommend DCH as a place to work has also increased significantly.***

The full results of the 2020 WRES Report are being reported as a separate item at this Committee.

8. Workforce Disability Equality Standard (WDES)

The WDES breakdowns are based on the responses to q26a *Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?* In 2020, the question text was shortened and the word 'disabilities' was removed but the question and WDES results still remain historically comparable.

The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information is reported to NHS England, and used to develop a local WDES action plan, to enable the Trust to demonstrate progress against the indicators of disability equality. The implementation of the WDES will enable us to better understand the experiences of our disabled staff.

The graphs contained in **Appendix 1** showcase data required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). They include the 2018 and 2019 DCH and benchmarking group median results for q5f, q11e, q13a-d, and q14 split by 'staff **with** a long lasting health condition or illness' compared to 'staff **without** a long lasting health condition or illness'. It also shows results for q26b (for staff

with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

At DCH, 32% of staff answered 'yes' to the question asking if they had a physical illness or disability which has or is expected to last more than 12 months.

For all 31 questions relating to 'Your Job', staff with Disability had higher negative scores to all 31 questions.

For all 11 questions relating to 'Your Manager', staff with Disability had higher negative scores to all 11 questions.

Results of the 2020 WDES Report and Action Plan is available on the DCH website.

9. Covid-19 classification breakdowns

This year, staff were asked four questions relating to their experience during the Covid-19 pandemic:

a.	Have you worked on a Covid-19 specific ward or area at any time?			☐ Yes	☐ No
b.	Have you been redeployed due to the Covid-19 pandemic at any time?			☐ Yes	☐ No
c.	Have you been required to work remotely/from home due to the Covid-19 pandemic?			☐ Yes	☐ No
d.	Have you been shielding?	☐ Yes, for myself	☐ Yes, for a member of my household		☐ No

The charts in **Appendix 2** show the breakdown of theme scores for staff answering 'yes' to each of these questions, compared with results for all staff in the organisation. Results are presented in the context of the highest, average and lowest scores for similar organisations.

Some key points include:

- Answering 'yes' to questions a, c and d results in **a lower theme score for ED&I**. The most impact appears to have been on the staff group who were shielding for a household member, which was the only score to drop below the national average.
- Scores suggest that shielding for a household member had the **biggest negative impact on morale** of the Covid-19 classifications

10. Plans moving forward

A number of priority workstreams are now in design and development stage with implementation dates commencing in April/May:

	Workstream	Summary	Timescale
1	**EDI Strategy**	Development of an EDI Strategy puts EDI at the heart of the Trust's culture, help demonstratre equitable and fair processes and supports us putting mechanisms in place to create, maintain and sustain a diverse workforce.	Signed off by end of March 2021
2	**Dignity & Respect at Work** *This will be a mandatory session for all existing staff & will be integrated into the Induction Programme for new staff.*	A development session to support **all staff** understand their personal & role responsibilities for role modelling respectful behaviour and calling out inappropriate behaviour.	Programme commences April 2021
3	**Compassion, Respect & Responsibility** *This will be a mandatory session for all line managers.*	A session for **line managers** which builds on the underpinning Dignity & Respect at Work session, to explore wider line management responsibilities for inclusive behaviours.	Programme commences April 2021
4	**Mental Health First Aid** *This will be a mandatory session for all line managers (and be available for other staff as required).*	A one day course will qualify **line managers** as an MHFA Champion, giving them an understanding of common mental health issues, knowledge and confidence to advocate for mental health awareness, provide ability to spot signs of mental ill health and develop skills to support mental health wellbeing.	Programme commences April 2021
5	**Bystander to Upstander**	A poster/communications campaign backed by skill sessions suitable for **all staff** to help challenge inappropriate behaviour through speaking up and reporting routes.	Programme commences April 2021

6	**Inclusive Leadership Programme for Middle Managers** *This will be a mandatory session for all line managers at B7+ initially, with a tailored rollout to staff Bands 1-6 in due course.*	A programme of workshops, self-directed learning and group activities **for leaders with line management responsibility** to develop confidence and understanding of the importance of creating inclusive, compassionate teams to address inequalities, improve team performance and organisational effectiveness.	Programme commences late May/early June 2021
7	**Staff Development Programme for staff from minority communities.** .	Participation in the programme is intended to accelerate career progression and support applicants to contribute to removing inequity by becoming knowledgeable and skilled agents of change.	Programme commences June 2021
8	**Reciprocal Mentoring for Inclusion**	A Change Programme that uses Reciprocal Mentoring as a tool for supporting greater systemic change that actively reduces inequity.	Programme commences August 2021
9	**Equality, Diversity & Inclusion Framework**	Workshops aimed at developing new policies and frameworks to ensure all staff processes and procedures are inclusive, fair and equitable.	Programme commences March 2021
10	**Setting up more Staff Networks**	Currently the Diversity Staff Network (for staff from minority communities) is operational and more Staff Networks for under-represented groups are being planned and encouraged.	Programme commences April 2021

The new Inclusive Leadership Programme and the Dignity & Respect modules will become compulsory for staff going forward if they wish to progress in the organisation. This will provide the consistency in terms of values and behaviours expected from those in leadership roles.

There will also be a Management Toolkit developed to support a range of management training and development needs, with inclusive practices sitting at the heart of resources and interventions, with initial implementation during June 2021.

A comprehensive Wellbeing Recovery Programme is being planned, to enhance existing support.

We will evaluate our progress on EDI and Wellbeing, ensuring it is measured against realistic and achievable targets which in turn will help us to learn, develop and continuously improve staff support and development.

11. Conclusion

We have evidence that supports the need to significantly improve inclusive practices at the Trust. The Staff Survey theme of Equality, Diversity & Inclusivity was reported as having a statistically significant lower score in 2020 and the results of the 2020 WRES Report have identified our Trust as one of the least performing Acute Trusts in respect of Indicator 6 (the percentage of EM staff experiencing harassment, bullying or abuse from staff in the last 12 months).

The range of interventions and activities outlined above will be integral to shifting the culture and embedding inclusivity in all of our activities across the Trust and must therefore be prioritised in order to progress the EDI, wellbeing and staff engagement agendas.

12. Recommendation

The People & Culture Committee is recommended to:

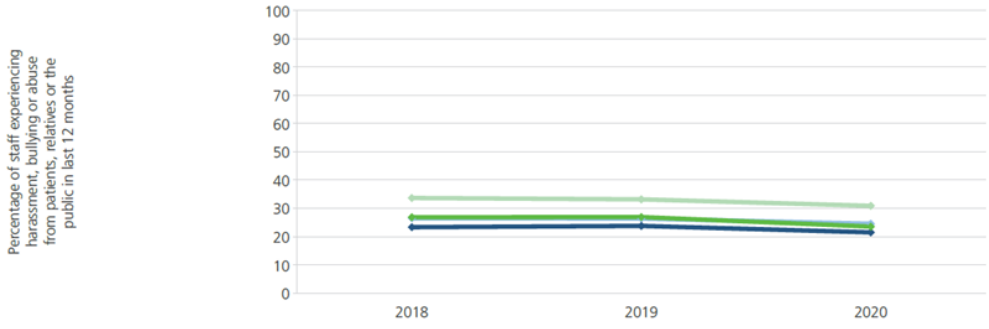
1. **NOTE** the content of the report
2. **APPROVE** the associated actions

Name and Title of Author: Julie Barber, Head of Organisational Development
Date: 10th March 2021

Appendices

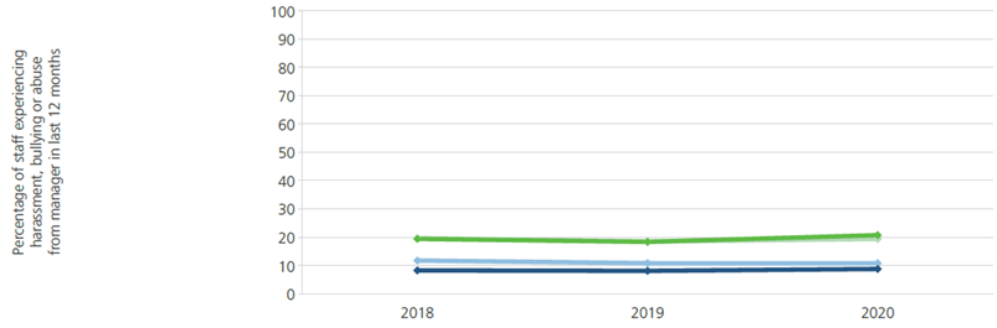
Appendix 1 – **Workforce Disability Equality Standard (WDES) – Staff Survey graphs**
Appendix 2 – Covid-19 classification breakdowns

Appendix 1 - **Workforce Disability Equality Standard (WDES) – Staff Survey graphs**



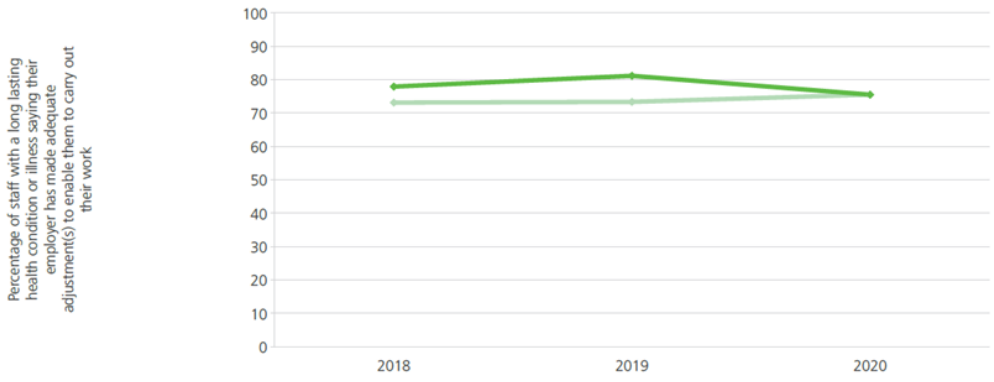
	2018	2019	2020
Staff with a LTC or illness: Your org	26.8%	26.9%	23.5%
Staff without a LTC or illness: Your org	23.3%	23.8%	21.5%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%
Staff without a LTC or illness: Average	26.5%	26.4%	24.5%
Staff with a LTC or illness: Responses	261	253	323
Staff without a LTC or illness: Responses	1,034	947	1,001

Average calculated as the median for the benchmark group



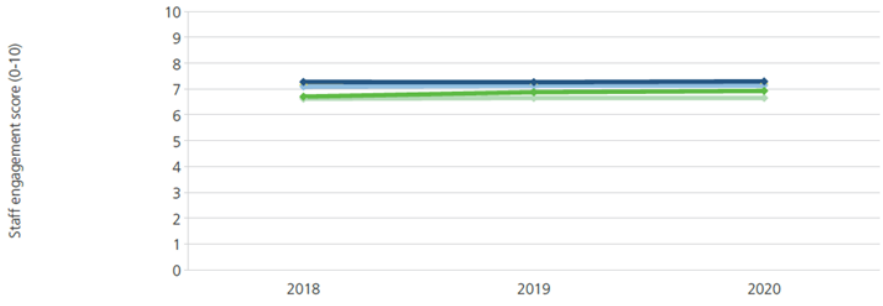
	2018	2019	2020
Staff with a LTC or illness: Your org	19.4%	18.3%	20.7%
Staff without a LTC or illness: Your org	8.2%	8.1%	8.7%
Staff with a LTC or illness: Average	19.6%	18.5%	19.3%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%
Staff with a LTC or illness: Responses	258	251	324
Staff without a LTC or illness: Responses	1,032	941	995

Average calculated as the median for the benchmark group



	2018	2019	2020
Staff with a LTC or illness: Your org	77.9%	81.2%	75.5%
Staff with a LTC or illness: Average	73.1%	73.4%	75.5%
Staff with a LTC or illness: Responses	145	154	196

Average calculated as the median for the benchmark group



	2018	2019	2020
Organisation average	7.2	7.2	7.2
Staff with a LTC or illness: Your org	6.7	6.9	6.9
Staff without a LTC or illness: Your org	7.3	7.3	7.3
Staff with a LTC or illness: Average	6.6	6.7	6.7
Staff without a LTC or illness: Average	7.1	7.1	7.1
Organisation Responses	1,316	1,232	1,356
Staff with a LTC or illness: Responses	263	255	326
Staff without a LTC or illness: Responses	1,041	952	1,013

Average calculated as the median for the benchmark group

Appendix 2 – **Covid-19 classification breakdowns**

COVID-19 CLASSIFICATION BREAKDOWNS

This year, staff were asked four questions relating to their experience during the Covid-19 pandemic:

a.	Have you worked on a Covid-19 specific ward or area at any time?	☐ Yes	☐ No
b.	Have you been redeployed due to the Covid-19 pandemic at any time?	☐ Yes	☐ No
c.	Have you been required to work remotely/from home due to the Covid-19 pandemic?	☐ Yes	☐ No
d.	Have you been shielding? ☐ Yes, for myself ☐ Yes, for a member of my household		☐ No

The charts below show the breakdown of theme scores for staff answering 'yes' to each of these questions, compared with results for all staff in the organisation. Results are presented in the context of the highest, average and lowest scores for similar organisations.

EQUALITY, DIVERSITY and INCLUSION

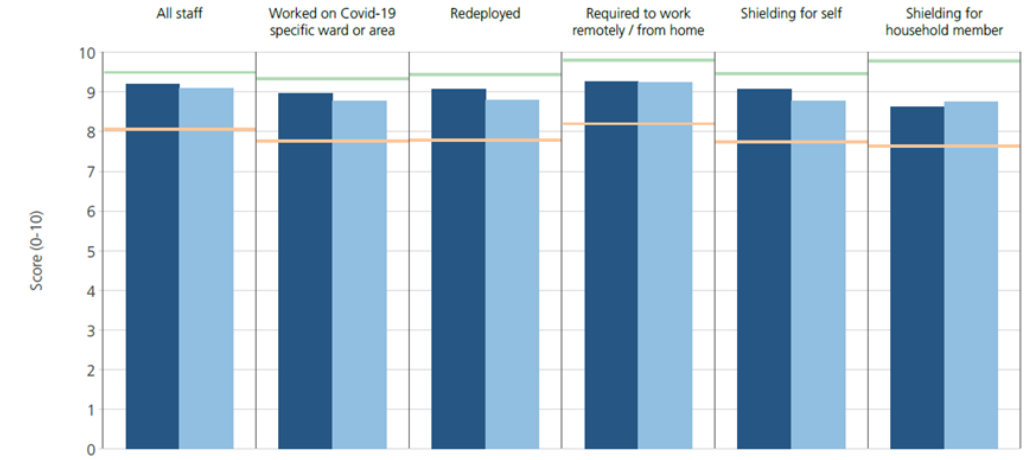
Table A indicates that answering 'yes' to questions a, c and d results in a lower theme score for ED&I. The most impact appears to have been on the staff group who were shielding for a household member, which was the only score to drop below the national average. The only group where the ED&I theme score was higher than all staff was 'Required to work remotely/from home'.

Table A:

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Equality, diversity & inclusion

NHS England

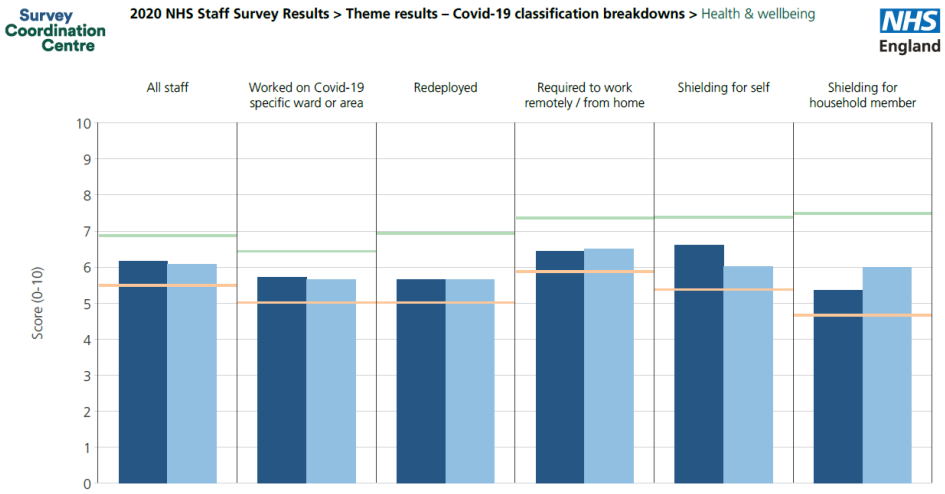


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	9.5	9.3	9.4	9.8	9.5	9.8
Your org	9.2	9.0	9.1	9.3	9.1	8.6
Average	9.1	8.8	8.8	9.2	8.8	8.8
Lowest	8.1	7.8	7.8	8.2	7.7	7.6
Responses	1,345	433	155	321	63	36

HEALTH and WELLBEING

Table B shows the H&W theme scores for those staff answering 'yes' to the above Covid-19 related questions. The scores for 'working from home', or 'shielding for self' are higher than those for 'All staff', with again, the theme score for those 'shielding for household member' being significantly lower than all other classification breakdowns, all staff and the national average.

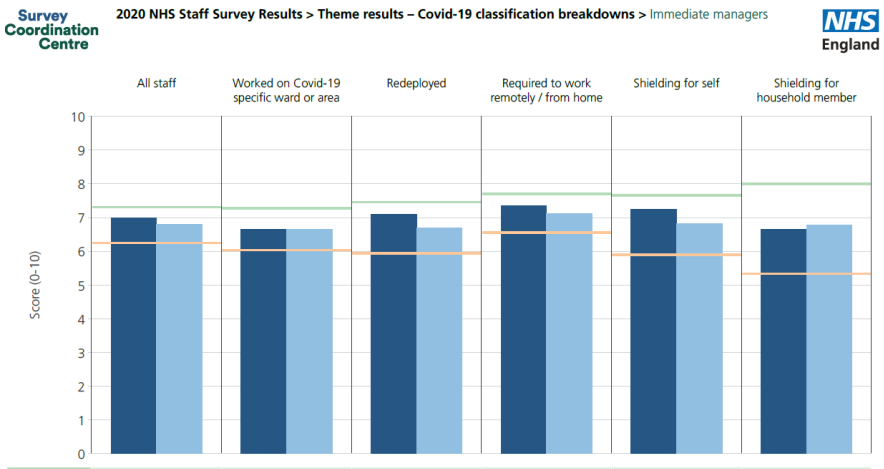
Table B:



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	6.9	6.4	6.9	7.4	7.4	7.5
Your org	6.2	5.7	5.6	6.4	6.6	5.4
Average	6.1	5.7	5.6	6.5	6.0	6.0
Lowest	5.5	5.0	5.0	5.9	5.4	4.7
Responses	1,352	435	154	321	65	37

IMMEDIATE MANAGERS

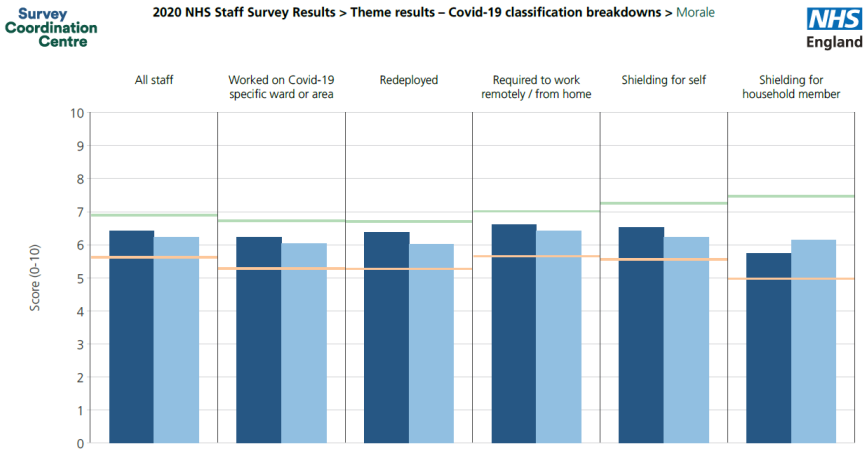
There was less variation from the score for all staff on this theme. The 'Immediate Manager' scores for staff who had worked on a Covid-19 ward and were shielding for a household member were the only two scoring lower than the 'All staff' score, with the other three C-19 classifications scoring higher. This indicates that staff who were redeployed, required to work remotely/from home, or were 'shielding for self' felt well supported by their immediate managers.



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.3	7.3	7.5	7.7	7.7	8.0
Your org	7.0	6.6	7.1	7.4	7.2	6.6
Average	6.8	6.7	6.7	7.1	6.8	6.8
Lowest	6.2	6.0	5.9	6.5	5.9	5.3
Responses	1,352	435	155	323	65	37

Scores shown in Table D suggest that shielding for a household member had the biggest negative impact on morale of the Covid-19 classifications that staff completed questions on. Morale scores were higher than all staff in those working remotely/from home and 'shielding for self' with only a slight decrease in score for those working on a Covid-19 ward/area. Morale scores for all groups other than 'shielding for household member' were above national average.

TABLE D:

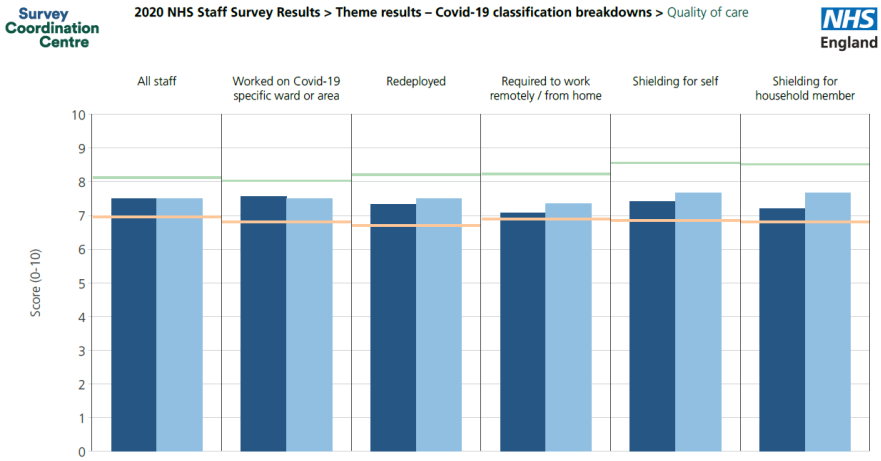


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	6.9	6.7	6.7	7.0	7.3	7.5
Your org	6.4	6.2	6.4	6.6	6.5	5.7
Average	6.2	6.0	6.0	6.4	6.2	6.1
Lowest	5.6	5.3	5.3	5.7	5.6	5.0
Responses	1,346	430	153	322	65	37

QUALITY OF CARE

With an 'All staff' score of 7.5, the 'quality of care' theme score for those staff who had worked on a Covid-19 ward or area was 0.1 point higher at 7.6, which is also 0.1 point higher than the National average. Other classifications scored slightly lower, with working remotely/from home affecting the score most negatively

TABLE E:



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	8.1	8.0	8.2	8.2	8.6	8.5
Your org	7.5	7.6	7.3	7.1	7.4	7.2
Average	7.5	7.5	7.5	7.4	7.7	7.7
Lowest	7.0	6.8	6.7	6.9	6.9	6.8
Responses	1,121	402	139	226	56	28

SAFE ENVIRONMENT – BULLYING and HARASSMENT

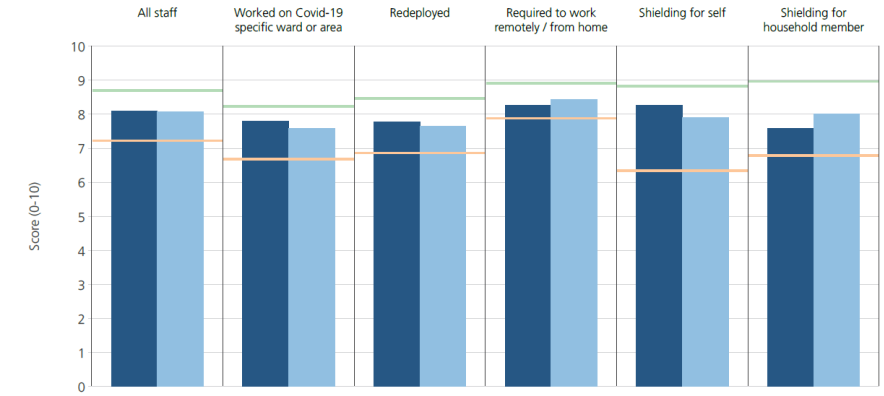
With an 'All staff' score of 8.1, this theme scored lowest again with those shielding for a household member. This is or particular interest, as the other two classifications where staff were not working on-site scored higher than 'All staff'. Scores for those shielding for a household member and working remotely/from home were both lower than national average, with the others scoring higher.

Table F:

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Safe environment - Bullying & harassment

NHS England



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	8.7	8.2	8.5	8.9	8.8	9.0
Your org	8.1	7.8	7.8	8.3	8.3	7.6
Average	8.1	7.6	7.7	8.4	7.9	8.0
Lowest	7.2	6.7	6.9	7.9	6.3	6.8
Responses	1,345	433	153	322	65	37

SAFE ENVIRONMENT – VIOLENCE

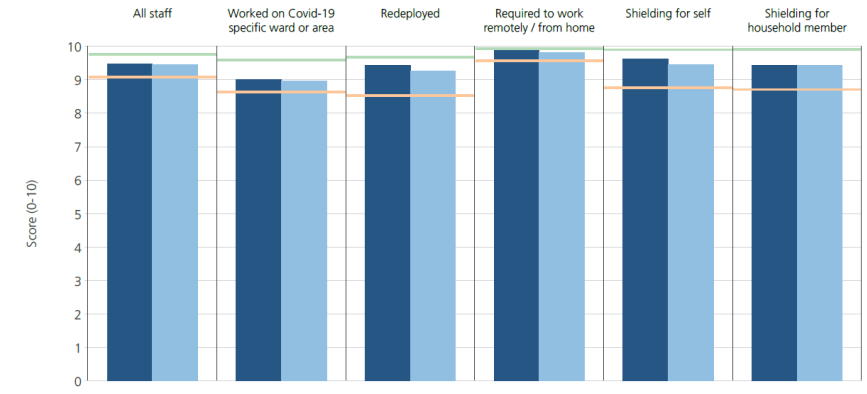
Table G shows that the scores for this theme are lowest in those working on Covid-19 wards or areas – though this is still slightly better than the national average. Scores are highest in those working from home or shielding for self, with the other classifications 0.1 point below the 'All staff' score. This would unsurprisingly indicate that working from home has a positive impact on staff feeling safe at work.

Table G:

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Safe environment - Violence

NHS England

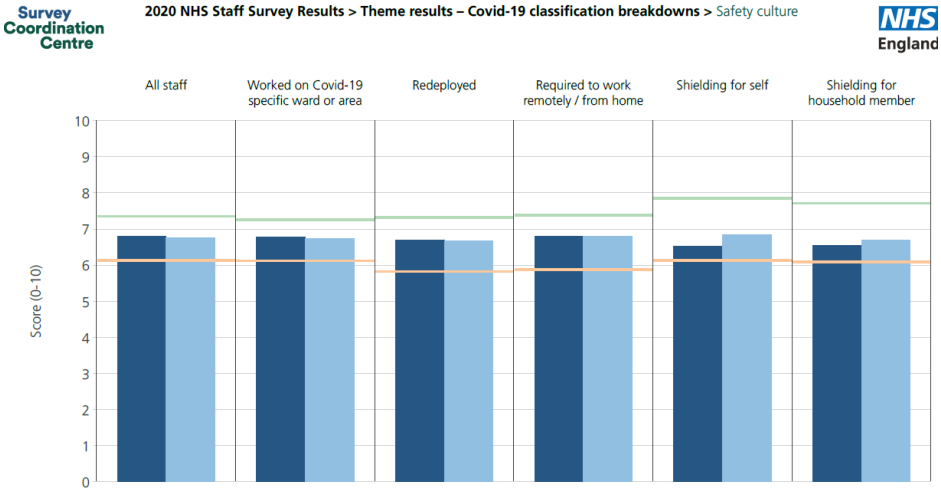


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	9.8	9.6	9.7	9.9	9.9	9.9
Your org	9.5	9.0	9.4	9.9	9.6	9.4
Average	9.5	9.0	9.3	9.8	9.4	9.4
Lowest	9.1	8.6	8.5	9.6	8.8	8.7
Responses	1,347	434	154	322	64	37

SAFETY CULTURE

These scores were consistent with the 'All staff score of 6.8, with the exception of both shielding groups, which both scored 6.5, and were the only classifications below national average.

Table H:



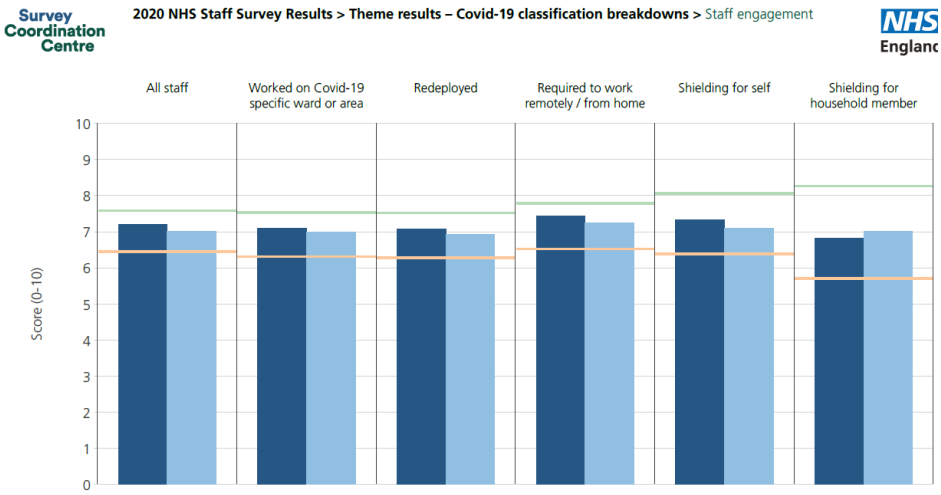
	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.4	7.3	7.3	7.4	7.8	7.7
Your org	6.8	6.8	6.7	6.8	6.5	6.5
Average	6.8	6.7	6.7	6.8	6.8	6.7
Lowest	6.1	6.1	5.8	5.9	6.1	6.1
Responses	1,347	436	155	320	64	37

STAFF

ENGAGEMENT

Results for this theme indicate that shielding for a household member impacts negatively on staff engagement, whilst those working remotely/ 'shielding for self' score higher than 'All staff'. This suggests that being away from the usual work environment and colleagues is not a factor in how engaged staff feel, in fact it can increase staff engagement.

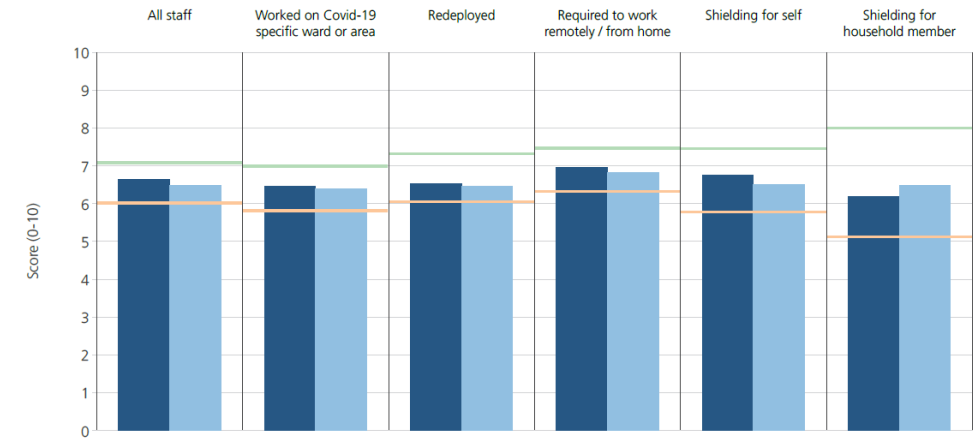
Table I:



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.6	7.5	7.5	7.8	8.1	8.3
Your org	7.2	7.1	7.1	7.4	7.3	6.8
Average	7.0	7.0	6.9	7.2	7.1	7.0
Lowest	6.4	6.3	6.3	6.5	6.4	5.7
Responses	1,356	436	155	323	65	37

TEAM WORKING

Scores for this theme were highest in those working from home & 'shielding for self' – both above the 'All staff' score and the national average. Redeployment and working on a Covid-19 ward/area did not significantly impact this theme score. Team working score for those 'shielding for household member' was 0.4 points lower than 'All staff' and 0.3 points below national average.



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.1	7.0	7.3	7.5	7.5	8.0
Your org	6.6	6.5	6.5	6.9	6.8	6.2
Average	6.5	6.4	6.5	6.8	6.5	6.5
Lowest	6.0	5.8	6.1	6.3	5.8	5.1
Responses	1,338	429	152	316	65	36

Meeting Title:	Trust Board
Date of Meeting:	31st March 2021
Document Title:	**Committee Risk Management Framework**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Trevor Hughes, Head of Corporate Governance

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Executive Team meeting	March 21	Approach supported – for Board approval
Non-Executive team meeting	March 21	Approach supported - for Board approval

Purpose of the Paper	This paper outlines the proposed framework for the management of risks to the Trust's strategic objectives as these develop within the current programme of work underway to refresh the Trust Strategy. The Board is asked to note prior discussion of the approach by both the Executive and Non-Executive teams and to approve the approach for implementation,							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The Trust is currently engaged in a review of its overall strategy in line with the '*Five Year Forward View'* and changing operating landscape for health and social care organisations; supporting greater partnership working and collaboration across commissioning and provider sectors. Legislative changes expected during 2021/22 that will see the establishment of Integrated Care Systems (ICS). These statutory bodies will embody collaborative partnership working arrangements across health, social care and third sector organisations to promote seamless care provision and increased efficiencies; adopting a 'place based' approach. Changes in the operating landscape provide opportunities for the Trust to be system leaders in the place based approach. DCHFT strategic objectives within the strategy will reflect these opportunities over the coming years, although the changing operating landscape will introduce new strategic risks for the Trust. It is therefore appropriate that the Board of Directors continues to ensure that governance arrangements are robust and are strengthened in the context of the changing landscape in order to remain sighted on evolving risks and respond in a timely manner. Following discussions by both the Executive and Non-Executive teams, the Board proposes to strengthen scrutiny, oversight, mitigation of and accountability for strategic risks by: • More closely aligning the work programmes of board sub-committees to the respective strategic objectives contained within strategy and associated elements of the annual plan; • Asking Board sub committees to scrutinise and monitor mitigations for respective strategic risks within the Board Assurance Framework (BAF); • Asking Board subcommittee Chairs to provide assurances to the Risk and Audit Committee who will maintain oversight of the BAF and internal control systems within the Trust. Review and monitoring of strategic risks and mitigations by respective Board							

	subcommittees will enable greater scrutiny, accountability and assurance by promoting greater discussion with the portfolio Executive and respective expert managers responsible for delivery of identified strategic objectives. The opportunity to better triangulate risks and mitigations with programmes of work; the opportunity for risk escalation to the Board will also be increased as the Board subcommittees meet on a monthly basis. Accountability for the system of internal control will remain with the Risk and Audit Committee which will retain oversight of the BAF.
Action recommended	The Board of Directors is asked to: 1. **NOTE** prior discussion of the proposal and 2. **APPROVE** the proposals to a. Align committee work programmes to the revised strategic objectives; b. Align the strategic risks to respective committees in order to provide greater monitoring, scrutiny, assurance and accountability; c. Risk and Audit Committee to retain oversight of the system of internal controls and oversight of the BAF.

Governance and Compliance Obligations

Legal / Regulatory	Y	The Board is required to demonstrate comprehensive oversight and mitigation of risks potentially impacting delivery of the Trust's strategy and strategic objectives
Financial	N	
Impacts Strategic Objectives?	Y	The proposal aims to strengthen the Boards oversight and risk mitigation opportunities to the strategic objectives.
Risk?	Y	The proposal aims to increase Board subcommittee oversight of strategic and operational risks and accountability via increased Board subcommittee scrutiny.
Decision to be made?	Y	The proposal is consistent across all seven areas of focus contained within the Trust's Risk Appetite Statement as it supports improved sight of areas of strategic risk.
Impacts CQC Standards?	Y	The proposal contributes to the Well Led standard.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

BAF

Meeting Title:	Board of Directors Part One
Date of Meeting:	31 March 2021
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – Deputy CEO
Author:	Paul Lewis – Head of Transformation & Improvement

Confidentiality:	*Not Confidential*
FOI Publishable?	*Yes/~~No~~*

Prior Discussion								
Job Title or Meeting Title			**Date**		**Recommendations/Comments**			
Executive Management Team								
Risk and Audit Committee			23rd March 2021		Recommended to Board			
Purpose of the Paper								
Note (✓)		✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

Summary of Key Issues

Summary

The Board needs to understand the Trust's strategic objectives and the principle risks that may threaten the achievement of these objectives. The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has assurance about the effectiveness of these controls.

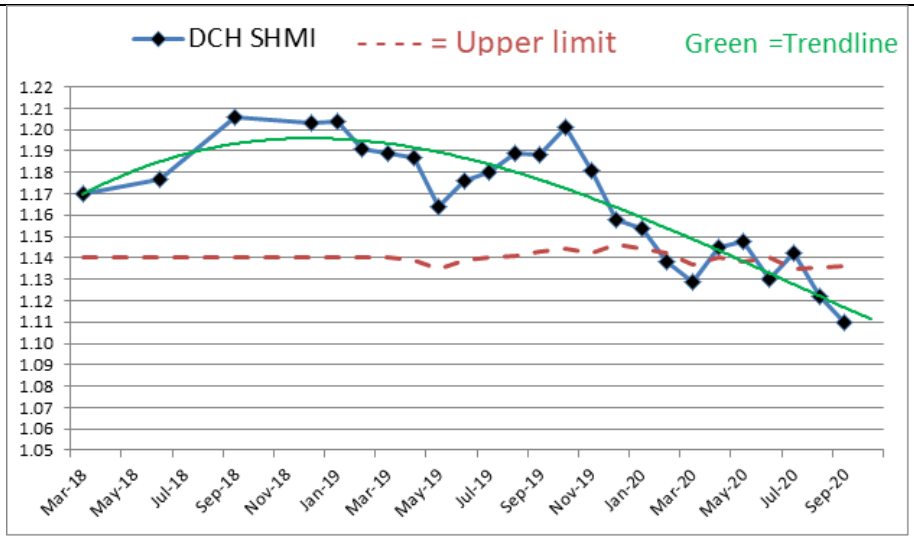
The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix.

The summary position of the BAF continues to highlight the Outstanding Services and Sustainable strategic objectives as the two which are most at risk of delivery.

All Executives were asked to review and provide updates where appropriate to the relevant BAF items.

The following section outlines the substantial changes made to the BAF since the last period:

- Objective 1 - Outstanding: Delivering outstanding services everyday.
  - Risk 6. SHMI now falls within the expected range for the Trust. The latest figure of 1.11 is the best it's been since Dec 2014, see below. As a result, the likelihood score reduced from 4 to 3.
- Objective 4 - Enabling. Empowering Staff.
  - Risk 6. Both the Divisional Directors have very competent deputies and all other leadership posts are filled. Recent recruitment has produced at least 2 other consultants who could step up if required.

	
Action recommended	The Risk and Audit Committee are requested to: • review the Board Assurance Framework; and • note the high-risk areas

Governance and Compliance Obligations

Legal / Regulatory	Y/~~N~~	
Financial	Y/~~N~~	The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.
Impacts Strategic Objectives?	Y/~~N~~	The Board Assurance Framework outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk?	Y/~~N~~	The Board Assurance Framework highlights that risks have been identified and captured. The Document provides an outline of the work being undertaken to manage and mitigate each risk. Where there are governance implications to risks on the Board Assurance Framework these will be considered as part of the mitigating actions.
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	Y/~~N~~	It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Impacts Social Value ambitions?	~~Y~~/N	
Equality Impact Assessment?	~~Y~~/N	
Quality Impact Assessment?	~~Y~~/N	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: MARCH 2021

BAF

Summary Narrative

The most significant risk which could prevent us from achieving our strategic objectives is not being **OUTSTANDING**

We may not have the appropriate workforce in place to deliver our patient needs. We continue to experience increasing dependency on the use of temporary clinical staff and the failure to maintain spend within the regulator ceiling for agency staff. The current COVID-19 Pandemic is putting severe strain on the Trust in the short term which may have consequences for the longer term achievement of the Strategic Objectives. However, it is too early to determine this. There is also a high risk in ensuring we are SUSTAINABLE. The Trust has submitted a plan for the second six months of 20/21 for an £11.6m deficit as it is clear that winter pressures and the investments needed to recover elective services will exceed the income allocated. Similarly the financial planning parameters for next year are not known and without a significant increase in income is likely to mean the trust will continue with a sizeable underlying deficit. The strength of control and assurance however remains the same.

There is a moderate risk in the strength of controls on ensuring we have **INTEGRATED** and joined up services. ED activity is high and demand for secondary care services continues to out strip supply. Stranded patient numbers are increasing and the pace of integrated demand management with primary and community services is not progressing at the required pace.

Objective	Range of Risk Scores	Strength of Controls	Strength of assurance
1. Outstanding: Delivering outstanding services every day. We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	**6-20**	**A**	**G**
2. Integrated: Joining up our Services. We will drive forward more joined up patient pathways, particularly working more closely with and supporting GP's.	**2-20**	**A**	**G**
3. Collaborative: Working with our patients and partners. We will work with all of our partners across Dorset to co-design and deliver efficient and sustainable patient-centred, outcome focussed services.	**06-Sep**	**A**	**G**
4. Enabling: Empowering Staff. We will engage with our staff to ensure our workforce is empowered and fit for the future.	**4-12**	**G**	**A**
5. Sustainable: Productive, effective and efficient. We will ensure we are productive, effective and efficient in all that we do to achieve long term financial sustainability.	**5-20**	**A**	**R**

0 - 4	Very low risk
5 - 9	Low risk
10 - 14	Moderate risk
15 - 19	High risk
20 - 25	Extreme risk

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
1	**Outstanding: Delivering outstanding services everyday.** We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	Strength of controls		A
		Strength of assurance		G

A) Principle RISKS						
REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving an outstanding rating from the Care Quality Commission within next two years (2021)	NL	3	4	12	6
R2	Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality can lead to reduced confidence in the organisation from the public and other bodies.	NL	3	4	12	6
R3	Not achieving national and constitutional performance and access standards	IR	4	4	16	12
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	2	6	6
R5	Not having the appropriate workforce in place to deliver our patient needs	EH/CY	4	5	20	12
R6	Failing to improve the Trust SHMI index	AH	4	3	12	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	Quality Committee reports on CQC, CQC Provider Information Collection & Insight data, CQC quarterly meetings. Dorset Quality Surveillance meeting in place that reviews hard and soft intelligence remain in 'Routine Surveillance' with acknowledgement to planned waiting list RTT risk.	G
C2	Performance monitoring and management of key priorities for improvement in quality and safe care (R2)	G	Divisional exception reporting and monitoring of quality improvement plans, SHMI and KPIs via The Quality Committee, alongside safety visits (NEDs) and back to floor time for Executive Directors to triangulate data with direct observations of care quality and safety. National NHSI /CCG and CQC reporting . Select number of KPIs not at standard being managed as Quality Improvement programmes (MUST/VTE) with investment required for Dementia team to address Dementia. Reductions seen in Patient experience relating to planned admission and cancelled operations - related to access constitutional standards - gap in assurance and reduced strength in delivery	A
C3	Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement (R3)	G	Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee	G
C4	Performance Framework - triggers for intervention/support (R3)	A	Performance monitoring via weekly PTL meetings and monthly Divisional Performance Meetings (through to Sub-Board and Board). Divisional Performance Framework presented at July 2019 Trust Board.	G
C5	Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership.	G
C6	Establishment of a Resourcing Operations Group. Monthly review of vacancies at Workforce Committee and SMT and tracking of junior doctor exception reports. (R5)	A	We review safe staffing through Board reports; junior doctor workforce issues through the GOSW reports; vacancy levels through the Workforce Committee and Board workforce reports; develop strategic solutions through the Resourcing Operations Group.	A
C7	People Strategy published May 2018. (R5)	G	Board sign off of 2018-2021 people Strategy in May 2018.	G
C6	Weekly review of medical workforce recruitment activity (R5 &6), Review of nursing vacancies and recruitment plans at the Resource Strategy Group.	A	Recruitment update report provided by recruitment team on a weekly basis. Workforce Planning capacity and capability gap - plan to address with increased resources. Dorset Workforce Action Board partner and joint working to mitigate and collectively tackle Dorset workforce issues	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board. The latest figure of 1.11 is the best it's been since Dec 2014	G
C8	Poor data capture drives patient coding which effects SHMI (R2)	A	Internal audit of sample of 1000 patient notes and national benchmarking undertaken by PWC	A
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
CONTROL	ASSURANCE	EVIDENCE
C1	November 2018 CQC rating as 'Good', remain on Routine Surveillance at system and regulator level through Quality Surveillance Group (QSG). Quarterly review with Regulators review of KPIs (CQC; NHSI/E).	CQC report. QSG notes. Other benchmark datasets via internal KPIs. National patient surveys
C2	National benchmarked datasets such as RCEM, ICNARC, HQIP, Surveys	Quality Committee and Divisional Reports
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and FPC reports
C2	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C5	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C1	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C6	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce Committee
C8	NHSE/I regular scrutiny and support (R6)	Ongoing NHSI/E reviews

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.		
ISSUE 1		**ACTION**
C1	CQC inspection process being redefined as it progresses due to global COVID-19 pandemic, which may result in some services not being reviewed to enable an 'outstanding' rating within the time frame of the Trust strategy.	Work with the CQC during the year through quarterly meetings and monitoring (as per the new methodology) to actively promote reviews of services where possible. To undertake our own review in 2021 to outline where we have triangulated evidence against CQC regulatory standards as a overview of the Trust position, whilst pending any inspection.
ISSUE 2		**ACTION**
C2	Significant resource constraints to deal with increased demand for both Elective and Emergency services.	System wide working on changes to care models and capacity and demand analysis to identify areas for additional investment. Escalation via Elective Care Board, Urgent Emergency Care Board, OFRG and SLT. Revised Phase 3 recovery plan submitted to Region and CCG as part of the recovery from COVID-19
ISSUE 3		**ACTION**
	Uncertainty over no deal Brexit and associated impact on procurement, staffing and charging of overseas patients.	Receiving regular briefings from regional team, participation in national data submissions, task and finish group reporting to Audit Committee.
C3	COVID-19 new virus that requires responsiveness to new guidance and ERPP planning	COVID-19 Incident Management Team in place with a steering group overseeing all actions and planning. Responsiveness to changes in national guidance daily with assurance reports on actions in place.
ISSUE 4		**ACTION**
C4	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
C5	Late visibility in junior doctor gaps from Deanery rotations	Regular communications with the Deanery, and profiling of historic gaps. "At risk" recruitment in anticipation of gaps.

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BAF

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
2	**Integrated: Joining up our services.** We will drive forward more joined up patient pathways particularly working more closely with and supporting GPs.			
		Strength of controls		A
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Emergency Department admissions continuing to increase per 100,000 population	IR	4	5	**20**	9
R2	Occupied hospital beds days continue to increase per 100,000 population	IR	3	4	**12**	9
R3	Having stranded patients	IR	3	4	**12**	9
R4	Not achieving an integrated community health care hub based on the DCH site	IR	4	4	**16**	6
R5	Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site	IR	2	1	**2**	6

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Reframed Urgent and Emergency care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is now the system SRO care and health inequalities. (R1,2,&3)	A	Upward reporting and escalation from UECB to SLT and DCH Board.	A
C2	Performance Framework reporting - triggers for intervention/support (R1,2&3)	G	Ward to Board reporting	G
C3	Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management (R3)	A	Patient flow project as part of operational efficiency strand of Transformation strategy.	G
C4	Proactively working in partnership with Integrated Community and Primary care Portfolio, West integrated Health and Care partnership, and Primary care networks. (R4)	G	Transformation (SMT) Reporting and Strategic updates to Board and ICPCS portfolio Board to SLT.	G
C5	Outpatient Improvements (within Elective Care Board Programme) (R5)	A	Reports to SMT and through to Board via Strategy updates	G
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Continuous high performance against national Emergency access standard (R1)	Performance reporting
C2	Primary Care engagement with Locality Projects - Cardiology, Dermatology, Ophthalmology, Diabetes and Paediatrics (R1).	SMT (Transformation) reporting and updates to Board
C3	Full community and primary care engagement (R2&3)	SMT (Transformation) reporting and updates to Board
C4	Dorset designated as a wave one ICS (R1-5)	ICS Memorandum of Understanding and shared collaborative agreement

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C3	Delayed Discharges - above national ambition (R3)	Implementation of national template for weekly reporting of delayed PTL. Executive challenge panel established July 2019
ISSUE 2		**ACTION**
C1	Emergency Department capacity (R1)	Business case development for investment in progress.
ISSUE 3		**ACTION**

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
3	**Collaborative:** We will work with all our partners across Dorset to co-design and deliver efficient and sustainable patient centred outcome focussed services.	Strength of controls		A
		Strength of assurance		G

A) Principle RISKS						
REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Failing to deliver services which have been co-designed with patients and partners	NL	3	3	**9**	6
R2	Not being at the centre of an integrated care system, commissioned to achieve the best outcomes for our patients and communities	PM	3	3	**9**	6
R3	Failure to play an integral role to MDT working leading to unsustainable services and poor outcomes	AH	3	2	**6**	6
R4	Workforce planning consequences across the system are not fully considered which de-stabilises individual organisation's workforce	EH/CY	3	2	**6**	4
R5	Not achieving a Dorset wide integrated electronic shared care record	SS	**2**	**3**	**6**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups	A
C2	CEO Leadership role in SPB, SRO for UECB and broader membership of SLT meetings including leading on the Dorset Clinical Networks and LMS (R2) The SW region has just prioritised the expansion of ED as their top priority. CEO is the SRO for the Dorset maternity transformation programme which is a national priority in the LTP. CEO Poole/RBCH and DCH have agreed that when appointments are reviewed for clinical leads at a specialty level to lead the transformation work, there needs to be balance between the East and West.	A	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	A
C3	All improvement programmes (Elective Care Recovery and Sustainability Programme) (R2)	G	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	G
C4	Divisions supported by the Transformation Team (DCH) integral part of Locality and service redesign meetings (R3)	G	SMT Meeting updates and escalation to Execs and Board where applicable	G
C5	Investment in DCH workforce planning team. DWAB resourced Dorset wide workforce planning capacity to co-ordinate (R4).	G	Regular reports considered at DWAB and escalated to Workforce Committee	G
C6	Dorset Care Record project lead is the Director of Informatics at Royal Bournemouth Hospital. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director. (R5)	G	Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	A
Overall Strength		G		G

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
REF	ASSURANCE	EVIDENCE
C1	Learning Disabilities engagement system wide (R1)	Safeguarding Adults work plan
C2	CSR collaboration of engagement with CCG (R2)	CSR outcome publication
C3	Leadership of Project 3 (Elective Care) and Project 4 (Urgent and Emergency Care) (R2)	Minutes, exception reports
C4	Primary Care collaboration in locality projects and DHC/Primary Care collaboration in frailty pathway. (R3)	Mid-Dorset Hub/ICS Minutes

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.		
ISSUE 1		ACTION
C1	Public engagement in all elements of developments is not embedded and requires strengthening strategies to deliver this	Communication Team, Head of PALS/Complaints and Transformation team to build and embed processes to deliver patient and public engagement
ISSUE 2		ACTION
C2	No independent assurance on controls in place for the Dorset Care Record (R5)	Progress reported through the Dorset Informatics Group. DCH input is progressing well but other partners are behind their milestones.
ISSUE 3		ACTION

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
4	**Enabling. Empowering Staff.** We will engage with our staff to ensure our workforce is empowered and fit for the future			
		Strength of controls		G
		Strength of assurance		A

A) Principle RISKS						
REF	**RISK**	**Exec Lead**	**Consequence Score**	**Likelihood Score**	**Risk Score**	**Target score**
R1	Not achieving a staff engagement score in the top 20% nationally	EH/CY	2	4	**8**	6
R2	Not benefitting from the successful delivery of our People Strategy	EH/CY	4	2	**8**	6
R3	Failure to deliver flexible and appropriate support service models	Exec team	3	4	**12**	9
R4	Not being an exemplar site for clinical research and innovation	AH	2	2	**4**	9
R5	Loss of training status for junior doctors	EH/CY	4	1	**4**	4
R6	Lack of medical leadership in senior management positions	AH	3	3	9	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Appointment of Head of OD to focus on the delivery of an Organisational Culture review programme (Second Round of Interviews July 2020). Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda. Health and Wellbeing champions have been identified to ensure local action plans developed and discussed. BAME staff network launched. (R1)	A	Staff survey results reported to the Workforce Committee and Board. Review of Equality & Diversity and Health and Wellbeing associated issues at respective Steering Boards and regular review at Workforce Committee.	A
C2	People Strategy approved at May 2018 Trust Board. (R2)	G	Workforce committee established to consider and report progress against People Strategy. Workforce Committee work plan tabled at Board in Jan 2020.	G
C3	Better Value Better Care Group provides model hospital overview. Proposal to establish SLAs and performance measures for support services. (R3)	A	Proposal to establish SLAs and performance measures for support services	A
C5	Strong clinical research and innovation programme (R4)	G	Reports to the Quality Committee	G
C6	Medical training activity and issues reviewed by the Director of Medical Education at the Medical Education Committee. Escalation through to the Resourcing Operations Group, and Workforce Committee as necessary. (R5)	G	Medical Education update provided at Workforce Committee. GMC junior doctor survey presented to board annually.	G
C7	Ensure a clinical leadership program is in place and appropriate delegates attending. (R6)	G	Both the Divisional Directors have very competent deputies and all other leadership posts are filled. Recent recruitment has produced at least 2 other consultants who could step up if required.	G
Overall Strength		G		A

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
CONTROL	**ASSURANCE**	**EVIDENCE**
C1	Appointment now in place. Staff survey promoted appropriately and launch of staff recognition scheme (R1).	Confirmation of appointment
C2	Assurance provided through Board agreement of the refreshed People Strategy. Progress updates to be provided regularly to the Workforce Committee (R2).	Trust Board approved People Strategy in May 2018. Updates to be reported to Workforce Committee on a regular basis.
C3	Wide ranging risk. Model hospital and corporate benchmarking information will assist with assurance (R3).	Benchmarking information
C5	Recognition via nominations and awards within Research networks (R4)	Wessex CRN awards 2019

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.		
ISSUE 1		**ACTION**
C1	Poor responses to the quarterly Staff Family and Friends test do not provide assurance of staff engagement (R1).	Focus on annual staff survey action plans. Review current people strategy.
ISSUE 2		**ACTION**
C2	Medical engagement continues to be hard to gauge. Recently formed Medical Engagement Forum too early to assess impact (R2).	Review effective of Medical Engagement Forum in 6 months. Consider engagement as part of the communication strategy review.
ISSUE 3		**ACTION**
C3	No clear metrics to determine appropriateness of support services, meaning assurance is limited (R3).	n/a
ISSUE 4		**ACTION**
C6	Gap in workforce reporting to highlight medical leadership vacancies (R6)	Include clinical leadership as part of talent management review

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BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
5	**Sustainable: Productive, effective and efficient.** We will ensure we are productive, effective and efficient in all that we do to achieve long-term financial sustainability	Strength of controls		A
		Strength of assurance		R

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not returning to financial sustainability, with an operating surplus of 1% and self sufficient in terms of cash	PG	2	5	20	12
R2	Failing to be efficient as outlined in the Model Hospital	PG	1	2	2	9
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	1	5	5	5
R4	Not using our estate efficiently and flexibly to deliver safe services	PG	4	3	12	12
R5	Failure to secure sufficient funding to ensure financial sustainability	PG	4	4	16	12

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	The Board approved a financial sustainability strategy in Sept 17. The Director of Finance and Resources is leading on the implementation of the strategy. The Transformation Team is supporting the delivering of key work streams in the strategy. (R1)	R	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	R
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	G
C4	Commercial Board reviews income against metrics, overseen by Better Value Better Care Group (R3)	G	Financial reporting mechanisms at commercial board and the Better Value Better Care Group	A
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey undertaken in Q2 of 19/20 to identify backlog maintenance levels and investment requirements. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is reported to the Senior Management Team, Finance and Performance Committee and Board of Directors for approval.	A
C7	The Trust is part of the Dorset Finance Collaborative Agreement to ensure that funds and control totals are amended across the system (R5)	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	G
Overall Strength		A		R

D) We have actually received these POSITIVE ASSURANCES...

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Internal audit reports on financial controls. (R1) and (R2).	BDO audit reports
C2	Model hospital information provides the information on our level of efficiency. (R2)	Model Hospital
C3	Estates Benchmarking (ERIC) return confirms efficient use of estate with opportunities in waste management (R2)	Estates Benchmarking (Eric) Return

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C1	(R1) No formal report discussed at the Better Value Better Care Group on the financial sustainability strategy or reported up to the Senior Management Team and Finance and Performance Committee.	(R1) Regular reports to the Senior Management Team and Finance and Performance Committee to be provided on implementation of the Financial Sustainability Strategy.
ISSUE 2		**ACTION**
C5	(R4) No independent assurance on compliance with statutory estates legislation	(R4) This was considered within the 2019/20 Internal Audit plan but not prioritised.
ISSUE 3		**ACTION**
C1	(R1) There is a risk we do not have the resource to make all of the transformation change happen timely.	An internal audit of the transformation programme was undertaken and reported to the November 2018 Audit and Risk Committee

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		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 4	Very low risk
5 - 9	Low risk
10 -14	Moderate risk
15 – 19	High risk
20 - 25	Extreme risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

A frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur 1 in 3 years	Do not expect it to happen/recur but it is possible it may do so 1 every year	Might happen or recur occasionally 1 every six months	Will probably happen/recur but it is not a persisting issue 1 every month	Will undoubtedly happen/recur,possibly frequently 1 every few days

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Identifying Risks

The key steps necessary to effective identify risks from across the organisation are:

a) Focus on a particular topic, service area or infrastructure
b) Gather information from different sources (eg complaints, claims, incidents, surveys, audits, focus groups)
c) Apply risk calculation tools
d) Document the identified risks
e) Regularly review the risk to ensure that the information is up to date

Scoring & Grading
A standardised approach to the scoring and grading risks provides consistency when comparing and prioritising issues.
To calculate the Risk Grading, a calculation of **Consequence (C)** x **Likelihood (L)** is made with the result mapped against a standard matrix.

Consequence score (C)
For each of the five main domains, consider the issues relevant to the risk identified and select the most appropriate severity scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. This provides five domain scores.

DOMAIN C1: SAFETY, QUALITY & WELFARE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage Short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) complaint Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Inadequate/poor performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

The average of the five domain scores is calculated to identify the overall consequence score

(C1 + C2 + C3 + C4 + C5) / 5 = C

Meeting Title:	Board of Directors Part One
Date of Meeting:	31 March 2021
Document Title:	**Corporate Risk Register**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Mandy Ford, Head of Risk Management and Quality Assurance

Confidentiality:	*n/a*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	23 March 2021	Recommended to Board

Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that risks corporate risks are effectively being managed and that controls are in place to monitor these. All care group risk registers are being reviewed by the Service Manager and Division. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report. All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.							
Action recommended	The Board of Directors is recommended to: • review the current Corporate Risk Register ; and • agree the movement to 'managed/tolerated' risks items: 463 and 468 • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances							

Governance and Compliance Obligations

Legal / Regulatory	Y	*Duty to ensure identified risks are managed*
Financial	Y	*Failure to manage risk could have financial implications*
Impacts Strategic Objectives?	Y	*Failure to manage risk will impact on the strategic objectives*
Risk?	Y	*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Decision to be made?	Y	*Movement of two workforce related risks to managed or tolerated within risk appetite.*
Impacts CQC Standards?	Y	*This will impact on all Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.*
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Audit and Risk Committee
Corporate Risk register as at 28.02.2021

Executive Summary
The Committee will also note that the highest risks are associated with the impact of delayed patient treatment due to suspension of services as a result of COVID 19 pandemic control, and the recruitment and retention of staff. There has been some impact on services as a result of staff absence linked to Covid-19.

1. Introduction

1.1 This report provides an update from the report presented to the January 2021 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 28.02.2021 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Committee with assurance of the continued focus on the identification, recording and management of risks across the Trust at all levels. These are managed in line with the Trust's Risk Management Framework. The Corporate Risk Register is an amalgamation of the operational risks that require Trust level oversight. The Corporate Risk Register items are the overarching cumulative risks that cover a number of services and the divisions where individual risk elements are being actively managed.

1.3 Presented to the Committee at Appendix 1 is a heat map of those items currently on the Corporate Risk Register with Appendix 2 providing the detail.

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)

2. Updates

2.1 449 – Financial Sustainability for year-end 31.03.2021 has been moved to managed after the risk has been mitigated for the current financial year. However, it is likely to reappear in the next financial year due to reductions in funding and potentially the ongoing and planned building projects for improvements to the Trust estate continue.

2.2 704 – Brexit – UK leaving the EU without a deal. This has now been moved to managed. Regarding workforce, the Trust has written to all our known EU staff and offered assistance with the settlement scheme application; good response in terms of those staff who have already applied. We are now capturing this info on ESR and data cleansing where there are ESR gaps so we can be assured we have correctly identified all eligible staff. The deadline for application to the scheme is 30 June 21.

3. Top Themes:

3.1 **Recruitment and retention:**

- 468 - Recruitment and retention of Medical staff across specialities (Extreme 20)

- 463 - Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff (Extreme 20)

3.1.1 Both of these risk register items are due for review at the end of March 2021. It is likely at this point that these risks will be reframed as the risks are evolving. From the detail in Appendix 2, it is noted that overall the service and divisional risks relating to staffing are reducing. As a result of this, it is expected that the corporate risk rating will lower. It is unlikely that these risks will resolve entirely with the international and national shortage of staff in some specialities, but it is recommended that these two risk items are moved to 'tolerated within risk appetite' and reviewed again in 6 months.

3.2 **Covid 19**

- 919 – Covid 19 (Extreme 25)

3.2.1 The Trust has seen a reduction in the number of patients being treated for Covid 19 over the last two months. PPE stock levels remain high with no reported issues on stock lines, and DCH remains at Major Incident Stand-by status along with the other Dorset acute hospitals. This is likely to remain at this level until nationally we are able to step down. Vaccinations continue to be delivered.

3.3 Constitutional standards

- 709 - Failure to achieve constitutional standards (elective care) (Extreme 20)
- 710 - Follow up waiting list backlog (Extreme 20)
- 450 - Emergency Department Target, Delays to Care & Patient Flow (Moderate 12)

3.3.1 All of these risks are due for review at the end of March 2021. During Covid 19 the access team have been contacting patients on the waiting lists during this period and some clinics have been held in different formats. Patients are being called in clinical priority with consultants having oversight of the lists. Monitoring standards were postponed when the pandemic commenced, but these are now being reintroduced.

3.3.2 Currently 709 and 710 remain as 'Extreme' due to the potential impact on patient safety and delay in treatment that could potentially lead to harm. (This is being mitigated by reviewing patients based on clinical need and any changes in presentations). There may be financial implications if constitutional standards are not met.

3.3.3 ED have continued to maintain the 4 hour standard throughout the pandemic. Area was enlarged to assist with patient flow. Any breaches are reported via Datix incident reporting.

3.4 Mortality

- 641 – clinical coding (High 15)
- 464 – Mortality Indicator (Moderate 12)

3.4.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group chaired by the Chief Medical Officer.

4 Divisional Emerging Risks (Details in Appendix 3)

4.1 <u>Urgent and Integrated Care</u>

- 461: Inpatient length of stay (Scored as 15 (High) (Moderate (3) x Certain (5))

4.2 Family Services and Surgical Division

- 866: External Multiagency delays resulting in delayed discharge of complex paediatric patients Scored as 16 (High) ((Major (4) x Likely (4)).
- 1037 – No transition services at DCH Scored as 20 (Extreme) (Major (4) x Certain (5))

4.3 These are all currently sitting at Divisional level where mitigations are in place. These are being highlighted as all three have the potential to impact on patient flow through the hospital, and could potentially cause patients harm by prolonged admissions. These are not new issues but have become more prevalent during the pandemic management due to the requirement to manage flow and bed capacity.

4. Conclusion

Risks continue to be regularly reviewed and updated in line with the Risk Management Framework and is linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place.

Some items within the Corporate Risk Register have not had any movement for some time despite the mitigations and actions in place due to international and national shortages of staff. These risks are:

- 463 : Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff. (This is underpinned by the Divisional and Service specific risk registers which are being managed locally within HR processes for recruitment and mitigated by the use of bank and agency staff)
- 468: Recruitment and retention of Medical staff across specialties. (This is underpinned by the Divisional and Service specific risk registers which are being managed locally within HR processes for recruitment and mitigated by the use of bank and agency staff)

5. Recommendation

The Audit and Risk committee is recommended to:

- review the current Corporate Risk Register ; and
- agree the movement to 'managed/tolerated' risks items: 463 and 468
- note the Extreme and High risk areas and actions
- consider overall risks to strategic objectives and BAF
- request any further assurances

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 09.03.2021

Appendices
Appendix 1 – Heat map
Appendix 2 - Corporate Risk Register
Appendix 3 – Emerging Divisional Risk Details

Heat Map

Appendix 1

		Likelihood Score				
score		1	2	3	4	5
		Rare (this will probably never happen 1x year)	Unlikely (Do not expect it to happen but it is possible 2 x year)	Possible (might happen occasionally - monthly)	Likely (will probably happen - weekly)	Certain (will undoubtedly happen – daily)
Consequence Score	5 Catastrophic	5	10	15	20	25 (919)
	4 Major	4	8	12 (450)	16 (474)	20 (468, 709,710, 641)
	3 Moderate	3	6	9	12 (464)	15 (641, 463,979)
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
	KEY	(↓number) (↑number)	Risk score has decreased since previous report Risk score has increased since previous report			
	Closed/Managed/Tolerated risks since last report	449 – Financial Sustainability for year-end 31.03.2021 has been moved to managed after the risk has been mitigated for the current financial year.				

Corporate Risk Register **Appendix 2**

The Risk Items on the Corporate Risk Register have been reviewed by the appropriate risk leads and the Executive Team.

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review)	Extreme (25) Consequence: Catastrophic Likelihood: Certain Reviewed: 24.02.2021
919	Covid- 19	Previous Rating	Extreme (25)
This will impact on all of our strategic objectives.		Lead Executive	Inese Robotham
How this risk has been scored: **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position/Progress/ Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible undetermined
• Confirmed cases of COVID-19 and associated hospitalisations have continued to fall across Dorset which shows that the national lockdown restrictions are having an impact. • The number of COVID-19 patients in Dorset hospitals has fallen to 269 from a peak of 552 on 19 January. Data at 19/2/20 • Staff Lateral Flow Device (LFD) testing remains in place along with the staff vaccination programme. • Mortuary capacity remains good at DCH. The Poole Port Mortality Support Unit has been stood down due to the improved situation following the surge in hospital deaths in both Bournemouth and Poole Hospitals. • The DCH COVID-19 Incident Management Team continues to meet daily Monday to Friday. • The virtual Incident Coordination Centre (ICC) remains is in place 0800hrs to 20:00hrs, Monday to Sunday in response to the Level 4 incident requirements. • PPE stock levels remain high with no reported issues on stock lines. • The Dorset health system operational 'Dorset Bronze Health & Care Tactical Group' and Health & Care Silver Groups remain in place and meet regularly. • National Daily COVID-19 SitRep reporting continues 7 days a week. • DCH remains at Major Incident Stand-by status along with the other Dorset acute hospitals.		Next review date	31.03.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 22.12.2017**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 30.12.2020
468	Recruitment and retention of Medical staff across specialities	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	
Strategic Objective 4 : Enabling: Failure to deliver flexible and appropriate support service models, Loss of training status for junior doctors, Not achieving a Dorset wide integrated electronic shared care record, Not achieving a staff engagement score in the top 20% nationally, Not being an exemplar site for clinical research and innovation, Not benefitting from the successful delivery of our People Strategy **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Catherine Youers Emma Hallett
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (Target) Target date	Moderate (12) Consequence: Moderate Likelihood: Likely 31.03.2025
We are reviewing the medical model within acute medicine to respond to areas of known skill shortages. We continue to look at joint consultant posts with partner organisations. Within business planning we have identified additional recruitment needs, which will need to be prioritised.		Next review date	31.03.2021
OTHER RISK REGISTERS LINKED TO RISK 468		**Current rating following local review**	**Target rating following completion of all actions**
884 Urology workforce		Extreme	Very Low
664 Gaps in gynaecology middle grade rota		High	Low
462 Lack of Ophthalmologists		Moderate	Low
465 ENT Medical Staffing		Moderate	Low
517 Acute Hospital at Home lack of medical cover		Low	Low
528 Acute medicine consultant vacancy		Low	Low
661 Lack of clinical director for pathology services		Low	Very Low
794 Dermatology Medical staffing capacity		Low	Low

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 23.11.2020
709	Failure to achieve constitutional standards (elective Care)	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : **Outstanding:** Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards Strategic Objective 3 Not achieving a 96% score on our friends and family test, Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities **Strategic Objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Inese Robotham
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Covid- 19 impacted on services – this is being reviewed as part of the start up work. • This is coded as extreme due to the potential impact on patient safety and delay in treatment that could potentially lead to harm – this is being mitigated by reviewing patients based on clinical need and any changes in presentations.		Next review date	31.03.2021
OTHER RISK REGISTERS LINKED TO RISK 709		**Current rating following local review**	**Target rating following completion of all actions**
473 Failure to meet 6 week diagnostic targets for paediatric and adult audiology 554 Non compliance with QS33 Rheumatoid arthritis in over 16s 555 Partial non compliance with NG100 – rheumatology Numerous incidents reported in relation to cancellation of clinics and increase in complaints regarding treatment delays.		Low Risk Low Risk Low Risk Potential for litigation due to patient harm	Low Risk Very low risk Very low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 23.11.2020
710	Follow up waiting list backlog	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	All services
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Robust reporting arrangements are in place to allow the services to oversee and manage all of the patients on their waiting lists. • Follow up waiting list numbers and profile of the waiting list is routinely reported to FPC. • Demand management tools such as attend anywhere and consultant connect being trialled in the Trust. • Access team have been contacting patients on the waiting lists and prioritising on clinical need, or changing presentation. • System wide a Pan Dorset view is being undertake to ascertain the level of harm caused to patients by the delay in being seen, where harm is deemed to have been caused and incident will be reported.		Next review date	31.03.2021

OTHER RISK REGISTERS LINKED TO RISK 709	Current rating following local review	Target rating following completion of all actions
462 Lack of ophthalmology service capacity to meet demand	Moderate	Low risk
472 Community paediatric long waits for ASD patients	Extreme	Moderate
505 Volume of patients on the gastroenterology follow up outpatient waiting list	Low risk	Low risk
557 Surveillance colonoscopy patients waiting greater than 6 months from their due date	Moderate	Very low risk
561 Volume of patients on the orthopaedic admitted list	Extreme	Low risk
581 Volume of patients on the dermatology outpatient waiting list	High	Low risk
777 Long waiting list for outpatient orthotic appointments	Low risk	Low risk
956 Excessive sleep diagnostic waiting times	Low risk	Very low risk
991 Increasing waiting list for paediatric dietetic outpatients	Moderate	Very low risk
1003 Ambulatory EEG waiting list	High	Low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 16.12.2020
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (Target) Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31/03/2021
During COVID we had a backlog of cases which were uncoded. Anything submitted that has an empty primary diagnosis field will be replaced with code R69 unspecified causes of morbidity. Residual codes go into undiagnosed group and an alert may then be generated. We are not seeing this for DCH at the moment but we will check. Backlog for all elective cases have cleared which did result in the non elective getting further behind. Currently carrying 7000 episodes of care un-coded. Concern was for those episodes prior to 01 November which are now down to 1000. (Annual figure of 60,000). Discussed regularly at the Hospital Mortality Group		Next review date:	31.03.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	High (16) Consequence: Major Likelihood: Likely Reviewed: 11.11.2020
979	Removal/reduction of education funding from HEE commencing April 21.	Previous Rating	Moderate (12)
Impact on Strategic Objectives		Lead Executive	Nicky Lucey covering
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models**,** Loss of training status for junior doctors **Strategic objective 5:** Sustainable **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain		Local Manager	Elaine Hartley
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date	Awaiting confirmation of actual impact 31.03.2021
This is currently being reviewed by the Dorset ICS with a plan to coordinate requests that meet system priorities by accessing a small pot of funding called Workforce Development funding. This however will be significantly less than what we would previously receive.		Next review date	31.03.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 28.06.2019 (originally opened 08.10.2015)**	CURRENT RISK RATING (following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 30.12.2020
463	**Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff**	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models Loss of training status for junior doctors Not benefitting from the successful delivery of the People Strategy **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain		Local Manager	Catherine Youers Emma Hallett Hilary Harold
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date	Moderate (12) Consequence: Moderate Likelihood: Likely 31.03.2025
• We have contracted with a new supplier to deliver international registered nurses. • We have increased resources for temporary staff and bank team • We have increased recruitment events, participating and arranging. • Developed different recruitment marketing tools including a Trust micro site and greater use of social media. • reviewed employer branding. • We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions. • Risk Register to be discussed at Workforce Committee		Next review date	31.03.2021

OTHER RISK REGISTERS LINKED TO RISK 463	Current rating following local review	Target rating following completion of all actions
452 OT and Therapy Capacity	High	Low
521 Dietetics – Renal team staffing levels	Low	Low
530 Ilchester staffing and capacity	Very low	Very low
540 CNS Band 6 staffing – KPIs not being met	Low	Very low
542 Lack of Neurorehabilitation service for outlying wards	Low	Very low
550 Dermatology Nurse Led Service staffing	Very low	Very low
649 Lack of staff with required competencies in Hospital Transfusion laboratory to meet MHRA requirements	Moderate	Very low
662 Pharmacy workforce vacancy rate	Moderate	Low
666 Nursing vacancies on Prince of Wales ward	Moderate	Low
726 CRCU Nurse workforce	Low	Very low
730 Critical Care outreach under resourced	Moderate	Low
734 Insufficient staffing for acute dietetic service	Moderate	Low
764 Recruitment and retention of theatre staff	Extreme	Low
769 Inadequate HEN staffing	Moderate	Very low
775 Care of the Elderly staffing levels	Moderate	Low
776 Inpatient therapy staffing	Moderate	Low
778 Inpatient physiotherapy staffing	Moderate	Low
780 Paediatric diabetes staffing (Div A)	High	Very low
795 HSCP staffing in neurophysiology	Moderate	Very low
801 Staffing shortfall in outpatients	Moderate	Very low
814 Lack of system support to staff the new hospital project on DCH site	High	Low
825 Mortuary staffing	Moderate	Low
835 Paediatric respiratory specialist physiotherapist and nurse	High	Low
836 Children's community nursing staffing	Extreme	Very low
840 Paediatric diabetes service staffing (Div B)	Extreme	Very low
842 Paediatric day surgery staffing	High	Very low
858 SCBU staffing	Low	Low
865 Paediatric diabetic staffing (Div A)	Moderate	Very low
876 Maternity staffing	Moderate	Low
881 Hand therapy staffing levels	Moderate	Low
906 Neonatal staffing levels	High	Very low
912 Unsafe staffing levels – Abbotsbury	Moderate	Very low
919 Covid 19	Extreme	Low
945 IUCS staffing levels	Low	Low
957 Physiologist staffing	Moderate	Low
959 DAIRS staffing	Low	Low
971 Staffing across care group A2	Moderate	Moderate
979 Removal reduction of education funding from HEE commencing April 2021	High	Low
987 Unsafe staffing levels on night shift on Purbeck ward	Extreme	Low
990 Kingfisher Acute dietetic staffing	High	Very low
1031 Staffing Coronary care	Low	Very low

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 25.02.2021
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: **Sustainable** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Discussion at SMT 15.01.2020 Electrical work is now underway Data is back and work will commence on this before financial year end Tender will be out shortly for new installation work - this will fall in to the new financial year. **UPDATED PROGRESS:** Electrical installation 30% complete. Data out to tender. To be complete by 31MAR21. New system install specification nearing completion. Roll out anticipated end Q1 FY20/21 **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Andy Morris
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (TARGET) Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31/03/2022
Completion of power installation adjusted to end of FEB 2021. Project delayed to FY21/22 Tender with procurement and almost ready for release to procure the replacement system which is currently planned to commence early new financial year, powers supply enabling works now nearing completion Scope complete. Now with Procurement for tender**.**		Next review date	31.03.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:14.01.2021
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective 1: Outstanding : Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit -** non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity -** National media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2021
Data is reviewed at the HMG with Dr Foster report information and analytics. This is discussed and minuted at this group, with actions being detailed and listed with in the HMG meeting and followed up to ensure action is taken. Anomalies and conditions that are flagging in the data are discussed and reviewed.		Next review date	31.03.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (following review)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 29.09.2020
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible** Linked to Risk Ref 709 – Failure to achieve constitutional standards.		Local Manager	Samantha Hartley
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING	Moderate (12) Consequence: Major Likelihood: Possible
Mitigation: Liaison Service on site. ED service activity is starting to rise again. Increase in activity is being managed with IMT ED area increase during pandemic to assist with flow and capacity.		Next review date	31.03.2021

Emerging Divisional Risks

Appendix 3

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 29.10.2018**	CURRENT RISK RATING (following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 14.02.2021
461	Patients stay too long in hospital due to (a) internal delays or (b) lack of external care capacity/inefficient process e.g. home with care or community hospital bed. Patients who remain in hospital for longer than they should are at risk of harm - falls or infection	Previous Rating	High
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING	Moderate (10) Consequence: Minor Likelihood: Certain Due date: 01.12.2021
Mitigation: A series of improvement projects have commenced:- **1. Patient Flow Programme -** Work streams: - Revise and roll-out consistent EDD Guidance to all inpatient wards - Recruitment of Patient keyworker role to support the approach of 'discharge on admission' - Create and implement 'Criteria led discharge' - Create a system to track Patient progress on inpatient wards - to minimize internal delays and as a tool to support management of escalation - Improve ward pharmacy processes **2. Reducing Long Length of Stay** - Implement stranded patient process across the Trust including formation of an exec-led panel - Revise the Leaving Hospital Policy - Improving pathways for self - funders - Implement an improved model of discharge to assess - Improving support for community pathways (e.g. community hospitals) **3. Length of Stay Delivery Group** - Implement a pan-Dorset service for self-funders - Establish a home-first service across Dorset - Improve End of Life Fast Track processes All three projects have groups and structures in place to oversee delivery. 1 and 2 are through the DCH Operational Effectiveness Programme 3. is through the UEC Delivery Board In addition, ongoing work as part of winter and beyond is seeking to:- - increase capacity of acute hospital at home - establish a frailty service to support the turnaround of older people - establish a team and process for medical outliers - implement additional support from the voluntary sector (The You Trust, CAB)		Next review date	31.03.2021

Movement on Risk Register: 	Risk Statement **It was added to the service risk register 24.12.2019 reviewed 11.05.2020, 07.10.2020 and escalated to the Divisional Risk Register 22.12.2020**	CURRENT RISK RATING (following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 25.02.2021
866	Increasing amount of children and young people are requiring the local authority to provide accommodation on discharge from Kingfisher Ward. These children often have emotional or mental health issues but do not require mental health inpatient admission but require a safe, nurturing environment away from the family home for their own safety and/or the safety of family/siblings. There are often delays in processes and locating appropriate placements resulting in prolonged hospital admission in an inappropriate environment. Additionally the Trust have seen a significant increase in patients admitted with Eating Disorders, requiring specialist input and / or inpatient bed. This has been highlighted both locally and nationally.	Previous Rating	Low Risk
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING	Low (6) Consequence: Minor Likelihood: Possible
Mitigation: • Weekly escalation though Division B updating with progress of patients. • Weekly reporting of incidents involving these patients to Dorset Healthcare to the Head of Mental Health Services • Formal escalations are happening when required between multiple agencies involved with patients. • Children all discussed at Weekly ILM meetings. • 1:1 support for patients being sought when appropriate for safety. Risk reports entered locally to evidence delays. • Training provided by DHCFT to support staff in restraint techniques • DHCFT providing staff (either from their own bank or agency) to support the staff on Kingfisher • Legal support and advice requested and provided in complex cases to try and assist with the correct placement being found for the children • Continued working with the Local Authority and DHCFT to find appropriate placement for the children. • Possibility of a safe room within the unit being explored. UPDATE: Once case has been escalated to NHSE with a view to prioritising finding a placement for one of the patients.		Next review date	25.03.2021

Movement on Risk Register: **NEW**	Risk Statement **Date added to Risk Register 09.02.2021**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 09.02.2021
1037	DCH has no transition service to safely and effectively transfer children to adult services from 14 years upwards. This is a national requirement highlighted by the CQC, RCPCH amongst other. Full business case submitted. There is no nursing input into transitioning children and young people into adult services. The CCN team are able to identify those children in their service who are transitionable, however not all children who require transition are managed by the CCN team, so the other children would be identified by their Paediatrician. The Paediatricians try to arrange formal handover of patient to Adult clinicians to make the process as smooth as possible and in some cases there are join clinics run in the process, but this does not happen for all. Without adequate staffing, fully functioning transition service for children and young people the mitigations that can be put into place to ensure that this process is as smooth and safe as possible is limited.	Previous Rating	New to register
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely
Mitigation: • Request for Band 7 1.0wte Transition Nurse Specialist has been put forward in 2021/22 business planning. Business case completed and submitted. • Some confusion noted over Transition Nurse Specialist Role and Diabetes Transition Service. These are two completely separate eservices and cannot be combined. • The Transition Nurse Specialist would work to develop a successfully functioning transition service to transition children and young people into adult services. • Transition processes should begin from 14 yrs old, with the intention that once successfully transitioned over, the Transition Nurse requires no further involved as this is not a young persons service (16-25yrs), but a transitioning service. This post would involve the recruitment of a Paediatric Nurse into this role.		Next review date	31.03.2021

Meeting Title:	Board of Directors Part One
Date of Meeting:	31 March 2021
Document Title:	**Workforce Race Equality Standard**
Responsible Director:	Nick Johnson, Deputy CEO
Author:	NHS England

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Equality, Diversity and Inclusion Steering Group		Report to be included on March PCC and Board agenda.
People and Culture Committee	22nd March 2020	Recommended to the Board

Purpose of the Paper	To advise the Board of the publication of this national report and assure members that the current (and previously approved) WRES action plan and wider ED&I plan have been informed by and are responding to the data in the 2020 report. To offer an opportunity for members to discuss the polarised outcome of benchmarking, particularly in relation to Indicators 6 and 7.							
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve*	
Summary of Key Issues	This is the 2020 National WRES report, published by NHS England on 25th February 2021. The data reported on is compiled by NHS England and utilises findings of the 2019 NHS Staff Survey, along with data from each Trust's ESR and TRAC as of 31st March 2020. DCH's submission was reported on to Workforce Committee and Board in the July 2020 Equality, Diversity and Inclusion Annual Report which was subsequently published on the DCH website here: EDI-Trust-Board-Report-July2020.pdf (dchft.nhs.uk) and includes the WRES Action Plan. This was submitted to the WRES team on 31st August 2020. DCHFT has been ranked one of the one of the best performing trusts for Indicator 7 'Percentage of staff believing that their trust provides equal opportunities for career progression or promotion' (see p.29) and one of the worst performing trusts for Indicator 6 'Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months' (see p.30). The Staff Survey Report on the agenda for today's PCC (22nd March 2021) includes responses to questions which will make up submissions for four of the indicators for both WRES and WDES which is next due to be submitted to the WRES team in August 2021.							
Action recommended	The Board is recommended to: 1. **NOTE** the National 2020 WRES report 2. **DISCUSS** any implications of the report's publication and how this will inform future ED&I programme actions							

Governance and Compliance Obligations

Legal / Regulatory	N	Each Trust's WRES data and action plan are published on their website annually as a requirement of the NHS Standard Contract.
Financial	Y	
Impacts Strategic Objectives?	Y	Impact on Trust People Strategy (2018-21) priority: Staff Health and Wellbeing.
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	The experience and engagement of our staff is part of the CQC 'Well Led' domain.
Impacts Social Value ambitions?	Y	A key Social Value Principle: Working together across DCH and with our Dorset system partners to improve health and well-being and reduce avoidable inequalities across our community. Principles: Recognised as a Good Employer, Increase Local Employment, Champion Diversity & Inclusion, Greener & Sustainable, Promote Civic Partnerships, Involve Our Community.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

"The publication of this report is a moment for humble reflection for national, regional, and local leaders alike. These findings, and the events of this year, show the need for equality and inclusion to be intrinsic to everything we do in the NHS and the People Plan clearly sets out the need to give these issues the same emphasis as we would any other NHS priority."

Prerana Issar
NHS Chief People Officer

NHS

Workforce Race Equality Standard

2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups

February 2021

WRES

Contents

NHS Workforce Race Equality Standard (WRES)

2020 data analysis report for NHS trusts and clinical commissioning groups

Version number: 1

First published: February 2021

Prepared by: WRES Implementation team

Classification: OFFICIAL

PAR289

Foreword

Prerana Issar
NHS Chief People Officer

The NHS was created in 1948 as an instrument of social justice. We collectively promised each other that everyone should have equal access to health outcomes, irrespective of income levels, sexual orientation, race, disability or gender.

Although we have made much progress to realise that promise, we still have a long way to go. In order to provide equality of health outcomes, we must also create equality within our NHS workforce. We come to work in the NHS because we believe that we can contribute towards improving lives, population health and health outcomes. It is through the commitment and dedication of our diverse and talented NHS workforce that we achieve these ambitions on a daily basis; yet we can only do so effectively by creating inclusive cultures in which all of our people can thrive. The continuing presence of discrimination is why we need to re-set the inclusion dial, together setting and attaining more ambitious leadership standards that demonstrably drive equitable outcomes for everyone. We must then build upon this progress year on year.

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for five years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to their white colleagues. The findings of this report do not make for a comfortable read, and nor should they. The evidence from each WRES report over the years has shown that our black and minority ethnic staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers. The persistence of outcomes like these is not something that any of us should accept. It is in recognition of these realities that the People Plan 2020/21 has 'belonging' as one of its four pillars.

Findings for WRES 2020 are impossible to separate from the context into which the report will be published. The country and the NHS have been challenged like never before by the COVID-19 pandemic, a disease that has been shown to disproportionately affect black and minority ethnic people. The murder of George Floyd in the USA spurred an immediate and long-overdue global conversation about race inequality. Attention has not been so sharply focussed on this agenda for decades, and it is right that we examine these findings with a view to quickening the pace of change, against this backdrop.

This year's report shows that, at the point at which the pandemic struck, inequalities were already present in the NHS. It is of note that much of this is experienced by black and minority ethnic staff as subtle processes and behaviours, that are often undetected by others. Three things emerge as key lessons to take from this year's findings:

- First, that delivering equality of outcome and opportunity should be the professional and moral obligation of every leader in the NHS. If it is not already happening, senior and executive leaders need to be accountable for developing and delivering urgent plans to eliminate inequality in their organisations.
- Second, that no one organisation is doing everything well. There are pockets of good practice across all WRES indicators, but no single organisation is exemplary. Every organisation must face up to its limitations and, as set out in the People Plan, develop measurable strategies to overcome them.

– Thirdly, the disproportionate rate of death among black and minority ethnic staff is intrinsically linked to their over-representation in some of the most at risk groups. Those who work on the front lines of public services are often more exposed to the risk of infection, just as they are more exposed to bullying, harassment and discrimination. This years' WRES reports a welcome increase in the diversity of our senior leadership. There has been a 42% increase in BAME Very Senior Managers, and a 22% increase in BAME trust board members since 2017. Alongside improved representation at senior level, cultures must become more inclusive as leaders develop pipelines of talent across the grades and throughout organisations, if we hope to see equality across the entire workforce.

The publication of this report is a moment for humble reflection for national, regional, and local leaders alike. These findings, and the events of 2020, show the need for equality and inclusion to be intrinsic to everything we do in the NHS and the People Plan clearly sets out the need to give these issues the same emphasis as we would any other NHS priority.

We need to act now to ensure that the cumulation of events of 2020 spur us to improve both equality for our black and minority staff and the experience of patient care for all. This is within our collective gift.

Prerana Issar
NHS Chief People Officer.

Key findings

+2.9%

As at 31 March 2020, **21.0% (273,359)** of staff working in NHS trusts and clinical commissioning groups (CCGs) in England were from a black and minority ethnic (BME) background. This is an increase from **18.1%** in 2017. There were **56,715** more BME staff and **37,602** more white staff in 2020 compared to 2017.

+41.7%

The total number of BME staff at very senior manager (VSM) pay band has increased by **45 (41.7%)**, from **108** in 2017 to **153** in 2020.

x1.61

White applicants were **1.61 times** more likely to be appointed from shortlisting compared to BME applicants; this is worse than in 2019 **(1.46)**. which itself showed no improvement on the previous year. There has been year on year fluctuation but no overall improvement over the past five years. It was **1.60** in 2017.

x1.16

BME staff were **1.16 times** more likely to enter the formal disciplinary process compared to white staff. This is an improvement on 2019 **(1.22)** and a significant improvement from 2017 when it was **1.37**.

30.3%

30.3% of BME staff, and **27.9%** of white staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is an increase for both groups. In 2016 it was **28.4%** for BME staff and **27.5%** for white staff.

0

The WRES indicators relating to perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, have not improved over time for both BME and white staff (please see table 1).

+1.6%

10.0% of board members in NHS trusts were from a BME background. This is an improvement from **8.4%** in 2019. In 2017, **7.0%** of board members were form a BME background

+22.2%

The number of BME board members in trusts increased by **61 (22.2%)** between 2019 and 2020.

For CCGs

This is the first time that we are reporting data for CCGs

66

Only **66 (34.6%)** of the 191 organisations took part in the NHS staff survey in 2019.

40.7%

Just **40.7%** of BME staff believed that their organisation provides equal opportunities for career progression or promotion compared to **88.3%** for white staff.

16.8%

16.8% of board members were from a BME background.

Key findings

Table 1:

WRES indicators for NHS trusts in England: 2016–2020

WRES indicator			2016	2017	2018	2019	2020
1	Percentage of BME staff	Overall	17.7%	18.1%	18.9%	19.7%	21.0%
		VSM	5.4%	5.3%	5.8%	6.5%	6.8%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.57	1.6	1.45	1.46	1.61
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.56	1.37	1.24	1.22	1.16
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.11	1.22	1.15	1.15	1.14
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	29.1%	28.4%	28.5%	29.8%	30.3%
		White	28.1%	27.5%	27.7%	27.8%	27.9%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	27.0%	26.0%	27.8%	29.0%	28.4%
		White	24.0%	23.0%	23.3%	24.2%	23.6%
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	BME	73.4%	73.2%	71.9%	69.9%	71.2%
		White	88.3%	87.8%	86.8%	86.3%	86.9%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.0%	14.5%	15.0%	15.3%	14.5%
		White	6.1%	6.1%	6.6%	6.4%	6.0%
9	BME board membership		7.1%	7.0%	7.4%	8.4%	10.0%

Key findings

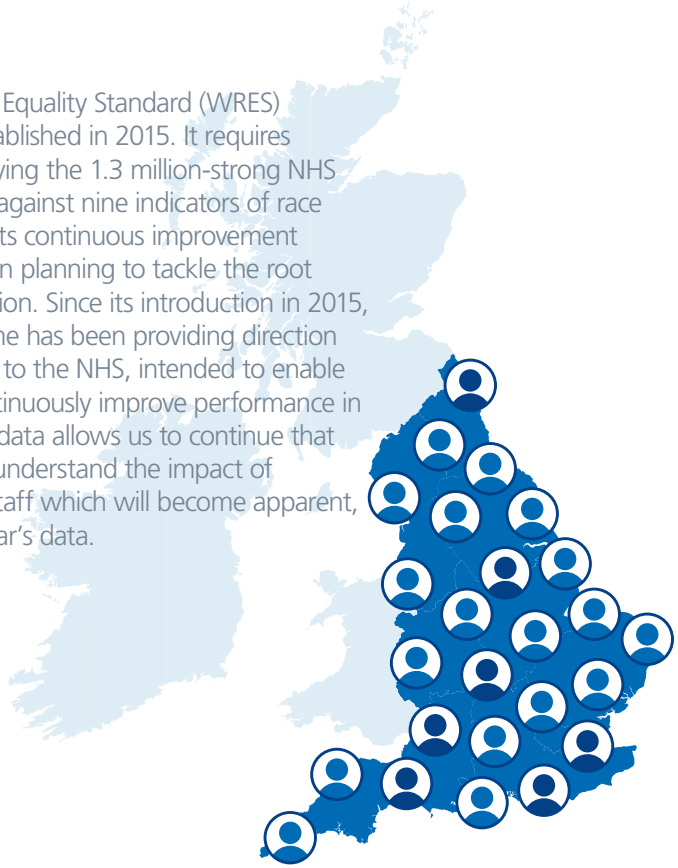
Table 2:

WRES indicators for clinical commissioning groups (CCGs) in England: 2020

WRES indicator			2020
1	Percentage of BME staff	Overall	14.3%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.41
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.65
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.71
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	8.3%
		White	11.6%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	28.4%
		White	23.6%
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	BME	40.7%
		White	88.3%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	10.2%
		White	4.4%
9	BME board membership		16.8%

Introduction

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination. Since its introduction in 2015, the WRES programme has been providing direction and tailored support to the NHS, intended to enable organisations to continuously improve performance in this area. This year's data allows us to continue that process, but also to understand the impact of COVID-19 on BME staff which will become apparent, no doubt, in next year's data.



The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination. Since its introduction in 2015, the WRES programme has been providing direction and tailored support to the NHS, intended to enable organisations to continuously improve performance in this area. This year's data allows us to continue that process, but also to understand the impact of COVID-19 on BME staff which will become apparent, no doubt, in next year's data.

Evidence from the Office of National Statistics and Public Health England shows that a disproportionate number of those who have died from COVID-19 are from black and minority ethnic (BME) backgrounds. In this way, the pandemic has shone a spotlight on the disparity of experience and opportunity between white and BME people in this country. While the majority of findings in this report are drawn from data collected before the pandemic, they are vital reminder of the context in which it struck. At the point at which the NHS staff needed support most, this report makes clear that many were already having worse experiences in the workplace than their white colleagues because of discriminatory systems and processes.

With five years of data collected against several of the indicators, we can now begin to take a long-term view of race equality for the workforce in NHS trusts. We can see more clearly than ever where there has been progress, and where more needs to be done. There are some positive findings in this report from 2020:

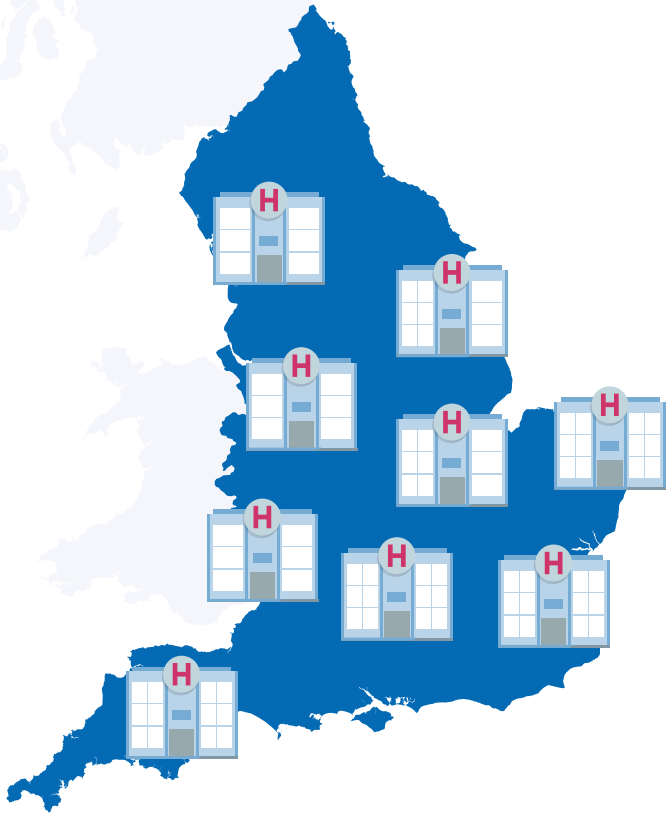
- **6.8% of very senior managers in NHS trusts are from a BME background (5.4% in 2016)**
- **10% of all trust board members are from a BME background (7.0% in 2017)**
- **the relative likelihood of BME staff entering the disciplinary process is at the lowest level since this data collection began**
- **the relative likelihood of BME staff accessing non-mandatory training is at the lowest level since this data collection began.**

Introduction

There remains striking regional disparity with gaps remaining as stark as in previous years in some regions, notably in London. There also remains wide variation between trusts, with some – such as the ambulance services – showing the greatest levels of inequality. In terms of trends with time, some are transforming to an outstanding degree, while others are making little or no improvement at all. **It is of particular note that no single organisation has results at the highest level for all the parameters.**

This year's report is also notable in that it is the first in which the WRES is publishing data for CCGs. CCG staff represent 2.1% of all NHS staff in trusts and CCGs, and this baseline data is key to mapping future trends for this cohort. At this time, it is apparent that BME staff in CCGs are significantly more likely to enter formal disciplinary process compared to white staff. Comparing BME with white staff in CCGs, half as many believe that they experience equal opportunities for career progression, and twice as many experience discrimination from a manager or other colleagues. For those CCGs who provided data, BME board membership stands at 16.1% (compared to 21% of the NHS workforce who identify as being from a BME background).

The data in this report is both a tool for improvement and a call to action. The insights contained here must be read and absorbed by all leaders in the system including HR Directprs, clinical leaders and boards and used to inform concrete policy interventions. Organisations are encouraged to work with the WRES resources and staff to help inform the adoption of local policies to reduce the existing disparities.



Introduction

The case for change has never been more profound and eradicating race inequality within the NHS workforce is, more explicitly than ever, a national priority. The NHS People Plan makes robust commitments on race equality, including an overhaul of recruitment practices, and specific targets to close representation and disciplinary gaps. But this is not an easy journey and will continue to require the committed and open-minded efforts of everyone in the system if we hope to make the NHS the employer its staff deserve.

Terminology

Throughout this report, we use the term "black and minority ethnic", expressed as the acronym BME, to refer to those members of the NHS workforce who are not white. This is largely driven by the data collection process. As set out in the WRES technical guidance, the definitions of "black and minority ethnic" and "white" used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity.

Methodology

The WRES requires NHS trusts and CCGs to self-assess against nine indicators of workplace experience and opportunity. Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers black and minority ethnic (BME) representation on boards. Short definitions of the nine WRES indicators are presented in Annex A of this report. The detailed definition for each indicator can be found in the **WRES technical guidance**. The technical guidance also includes the definitions of "white" and "black and minority ethnic", as used throughout this report and within the narrative for the WRES indicators. This report presents data for all NHS trusts in England, against all nine WRES indicators, and where possible, makes comparisons to the 2016, 2017, 2018 and 2019 WRES data.

Data sources

WRES data for 2020 was collected through individual NHS trust and CCGs submissions via the NHS Digital Strategic Data Collection Service (SDCS). A return rate of 100% for trusts and 98% for CCGs was achieved. This report also includes workforce data from the NHS workforce statistics website. The NHS workforce statistics website data includes both CCGs and NHS trusts. This data is used because it is more robust and published on a regular basis. Using this data will make it possible to monitor changes more accurately. Unless otherwise stated, data was taken from the 2020 WRES SDCS submissions.

Data analyses

For the purpose of data analyses and presentation, organisations have been grouped by the new seven NHS geographical regions – East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. Trend data analysis will be limited to 2017 data due to the better quality and reliable data starting that year.

For indicators 2, 3 and 4, statistical analyses included the "four-fifths" rule. The "four-fifths" ("4/5ths" or "80 percent") rule is used to highlight whether practices have an adverse impact on an identified group, e.g. a sub-group of gender or ethnicity. For example, if the relative likelihood of an outcome for one sub-group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having an adverse impact.

WRES indicator 1

Key supportive data

Table 3

Staff in NHS trusts and CCGs by ethnicity: 2016 – 2020

In 2020, the combined BME workforce in NHS trusts and CCGs was 21.0% (273,359). Across all NHS trusts and CCGs, there were 63,844 more BME staff in 2020 compared to 2016. Over the same period, the number of white staff increased by 43,656.

	Headcount			Percentage		
Year	White	BME	Unknown	White	BME	Unknown
2016	922436	209515	54105	77.8%	17.7%	4.6%
2017	928490	216644	52455	77.5%	18.1%	4.4%
2018	931704	230189	53780	76.6%	18.9%	4.4%
2019	943385	246301	58873	75.6%	19.7%	4.7%
2020	966092	273359	61119	74.3%	21.0%	4.7%

Data source: NHS workforce statistics website.

View more detailed data here

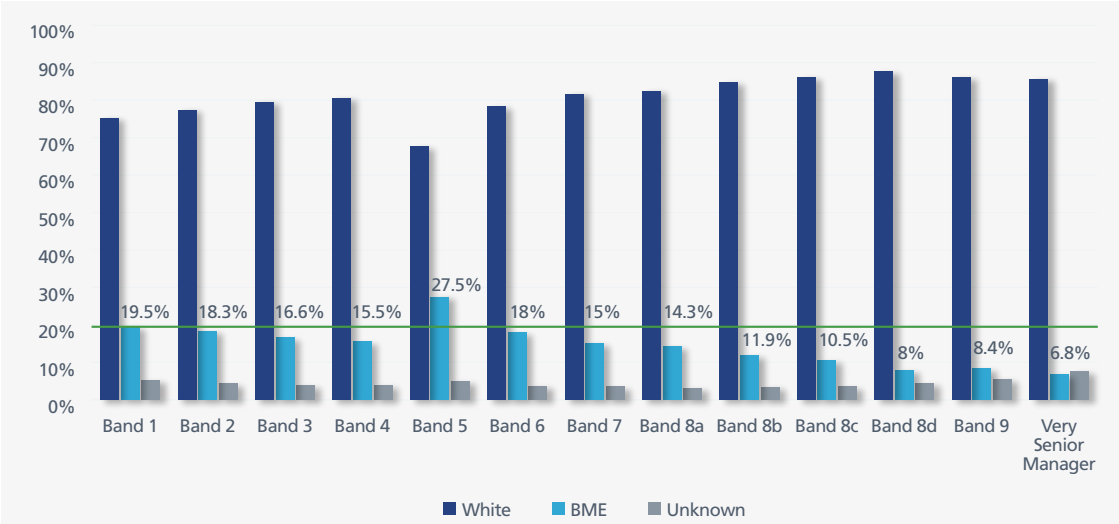
WRES indicator 1

Key supportive data

Figure 1

Percentage staff by AfC pay band and ethnicity for all NHS trusts and CCGs: 2020.

The green line represents the target of 19% representation at every pay band.



2020

21%

2019

19.7%

View more detailed data here

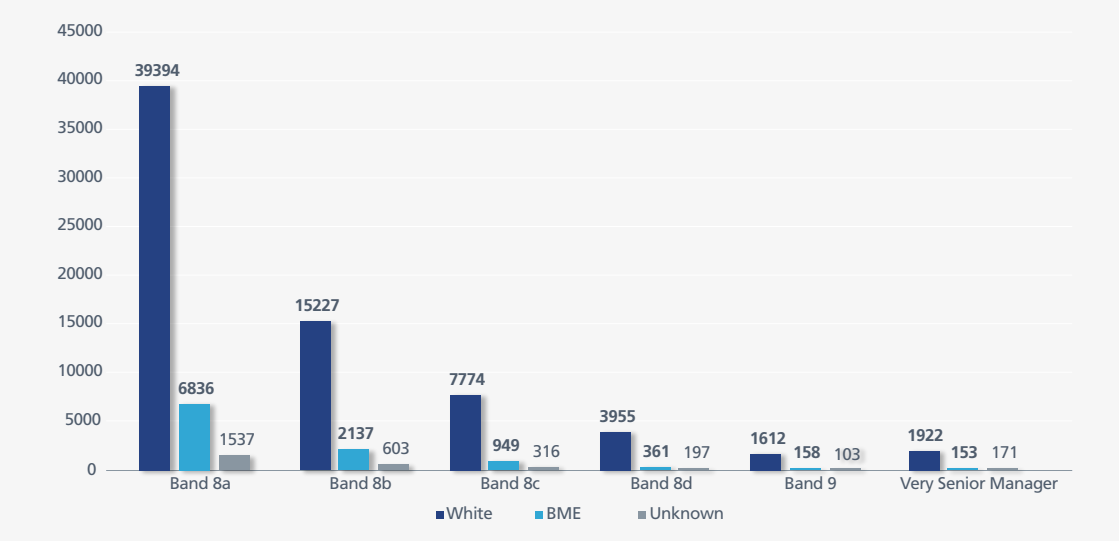
WRES indicator 1

Key supportive data

Figure 2

Number of staff by AfC pay bands (8a to VSM) and ethnicity for all NHS trusts and CCGs:

2020: 9.2% (1,621) of staff at AfC pay bands 8c and above are from a BME background. This is significantly lower than the 21.0% of all BME staff in NHS trusts and CCGs. NHS trusts and CCG organisations must do more to build the talent pipeline if they are to deliver the model employer ambitions.



View more detailed data here

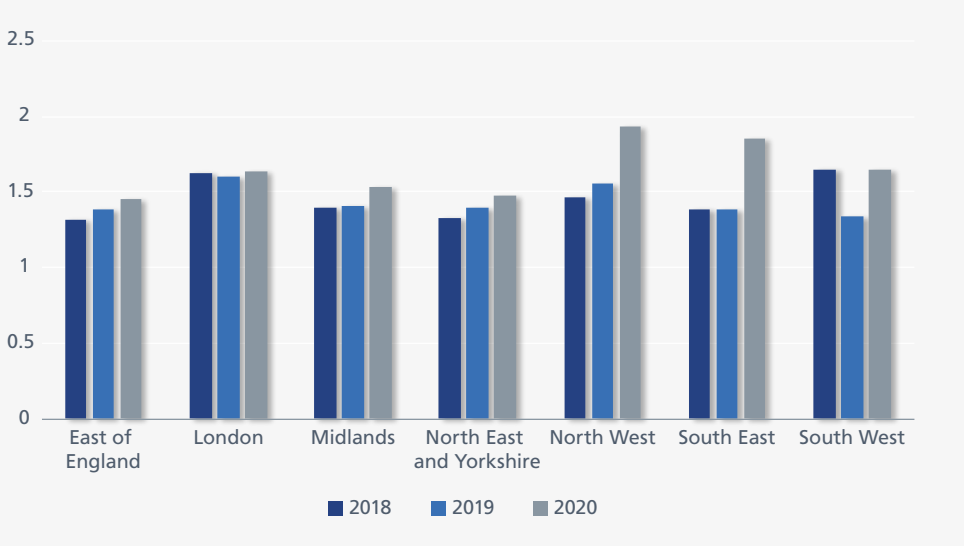
WRES indicator 2

Key supportive data

Figure 3

Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants by region: 2018 – 2020:

All regions have seen a deterioration for BME applicants, with the North West region being the worst performer, London had the smallest deterioration.



View more detailed data here

WRES indicator 3

Key supportive data

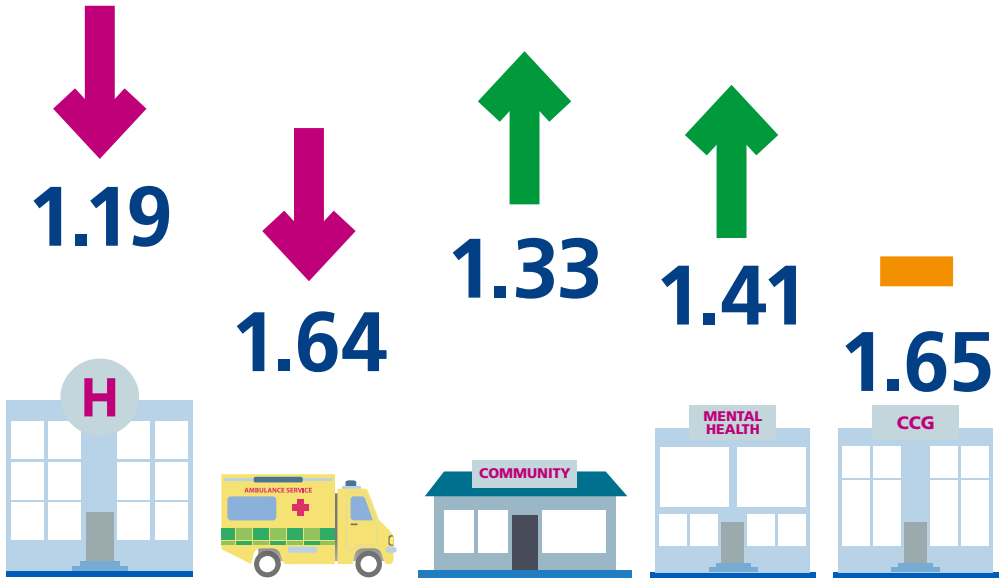
Table 4

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff by trust type: 2016 – 2020:

Acute trusts observed slight deterioration on this indicator in 2020 compared to 2019. Ambulance trusts had a significant deterioration from 1.39 in 2019, to 1.64 in 2020.

– For the CCGs that provided data for this indicator, BME staff were 1.65 times more likely to enter the formal disciplinary process compared to white staff.

Organisation type	2016	2017	2018	2019	2020
Acute	1.45	1.26	1.14	1.17	1.19
Ambulance	1.8	1.73	1.69	1.39	1.64
Community provider	2.48	3.35	2.7	1.5	1.33
Mental health	1.33	1.58	1.74	1.66	1.41
CCG					1.65



View more detailed data here

WRES indicator 4

Key supportive data

Table 5

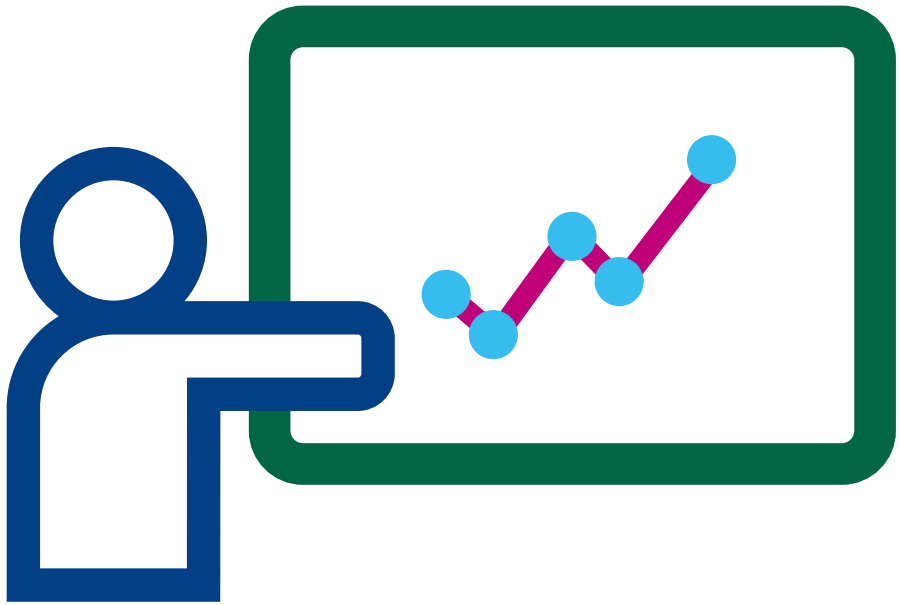
Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff by region: 2019 – 2020:

For London, South East and South West regions, BME staff are relatively more likely to access non-mandatory training and CPD compared to white staff. For all regions the data now falls within the non-adverse range of 0.80 to 1.25, based on the four-fifths rule.

Trusts should consider how to use non-mandatory training and CPD to improve career progression and promotion for BME staff.

For CCGs that provided data for this indicator, BME staff were relatively more likely to access non-mandatory training and CPD compared to white staff.

Region	2019	2020
East of England	0.92	1.03
London	0.95	0.90
Midlands	1	1.11
North East and Yorkshire	1.05	1.04
North West	1.26	1.20
South East	0.99	0.96
South West	0.97	0.88



View more detailed data here

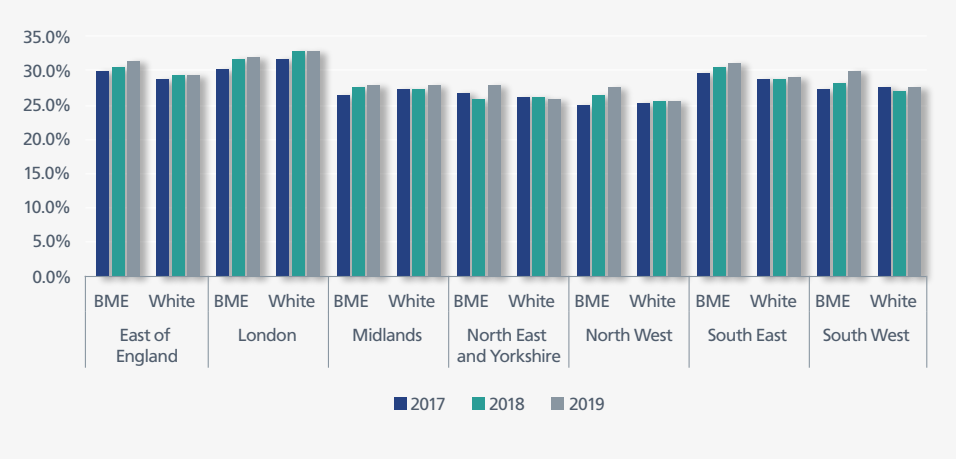
WRES indicator 5

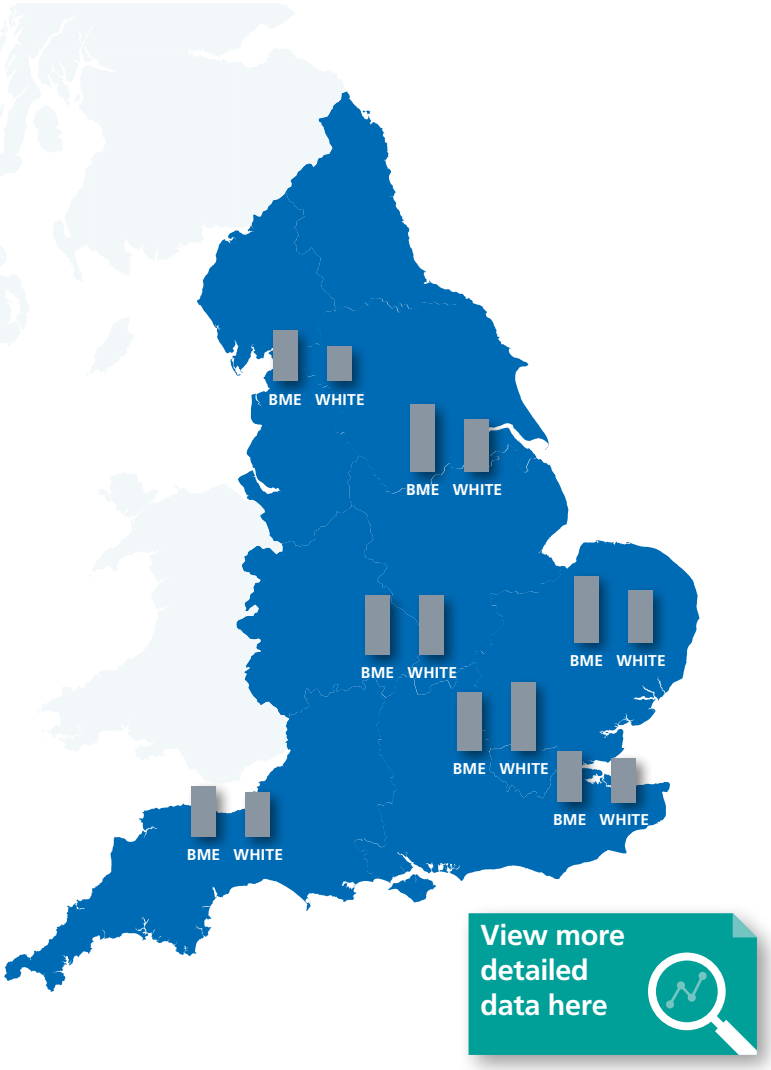
Key supportive data

Figure 4

Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months by region: 2017 – 2020

Across most of the regions, there has been an increase in the proportion of both BME and white staff who experienced harassment, bullying or abuse from patients, relatives or the public. With the exception of North East and Yorkshire, the same trend is seen for white staff. London has the highest percentages for this indicator, for both BME and white staff. For London, a higher percentage of white staff reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.





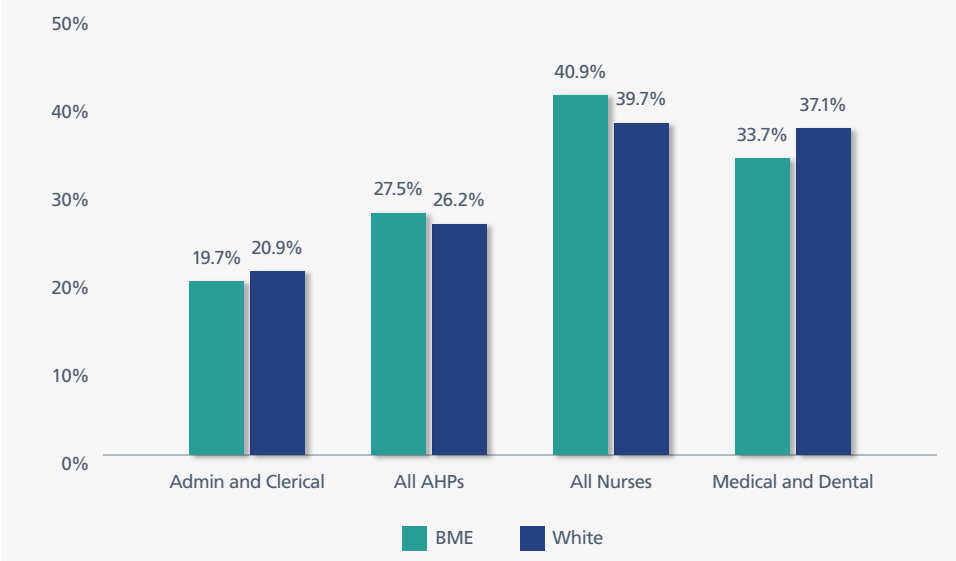
WRES indicator 5

Key supportive data

Figure 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months by staff group (2019)

BME nurses had the highest proportion of staff that experienced harassment, bullying or abuse from patients, relatives or the public. BME staff working in administration and clerical roles had the lowest proportion.



View more detailed data here

WRES indicator 6

Key supportive data

For 82.7% of trusts, a higher proportion of BME staff compared to white staff experienced harassment, bullying or abuse from colleagues in the last 12 months.

Figure 6

Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: 2017 – 2019

Across all regions except North East and Yorkshire, the proportion of BME and white who experienced harassment, bullying or abuse from staff decreased. The North East and Yorkshire region had the biggest percentage point difference (6%) between BME and white staff experiencing harassment, bullying or abuse from staff in the last 12 months.

View more detailed data here

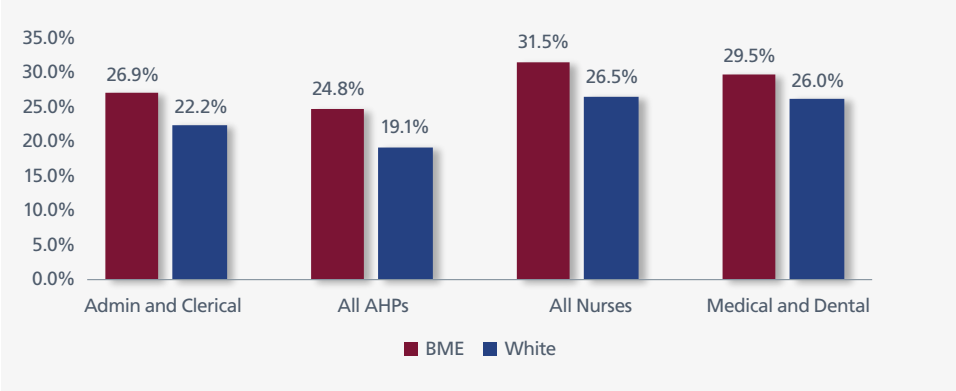
WRES indicator 6

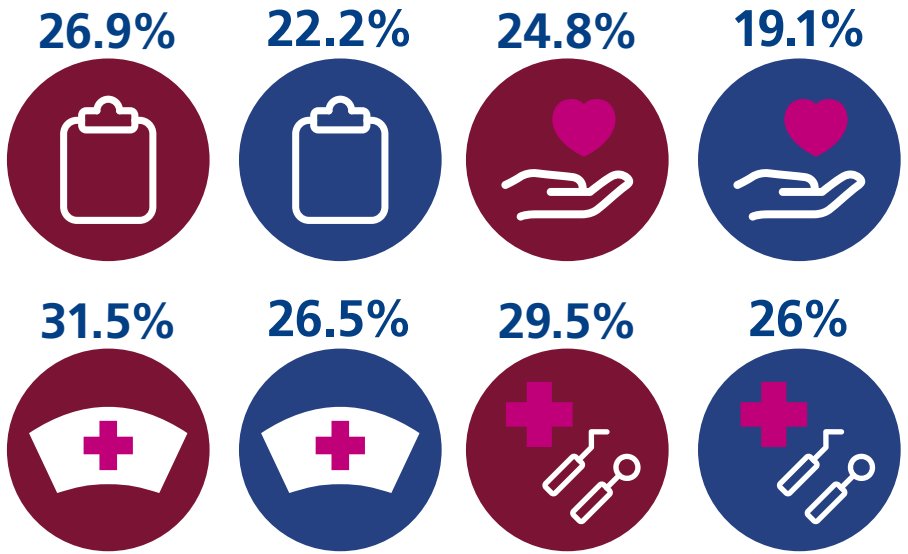
Key supportive data

Figure 7

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months by ethnicity by staff group (2019):

BME staff in nursing roles and in medical and dental roles reported the highest levels of harassment, bullying or abuse from staff.





View more detailed data here

WRES indicator 7

Key supportive data

Table 6

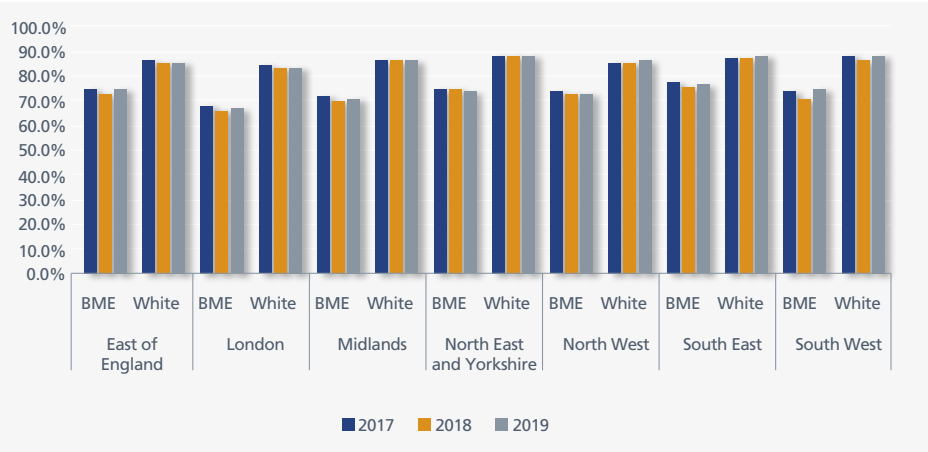
Percentage of staff believing that their trust provides equal opportunities for career progression or promotion: 2015 – 2019:

The proportion of BME and white staff that believed their trust provides equal opportunities for career progression or promotion increased slightly in 2019 compared to 2018.

	2015	2016	2017	2018	2019
BME	73.4%	73.2%	71.9%	69.9%	71.2%
White	88.3%	87.8%	86.8%	86.3%	86.9%

Figure 8

Percentage of BME staff believing that their trust provides equal opportunities for career progression or promotion by region: 2017 – 2019



View more detailed data here

WRES indicator 8

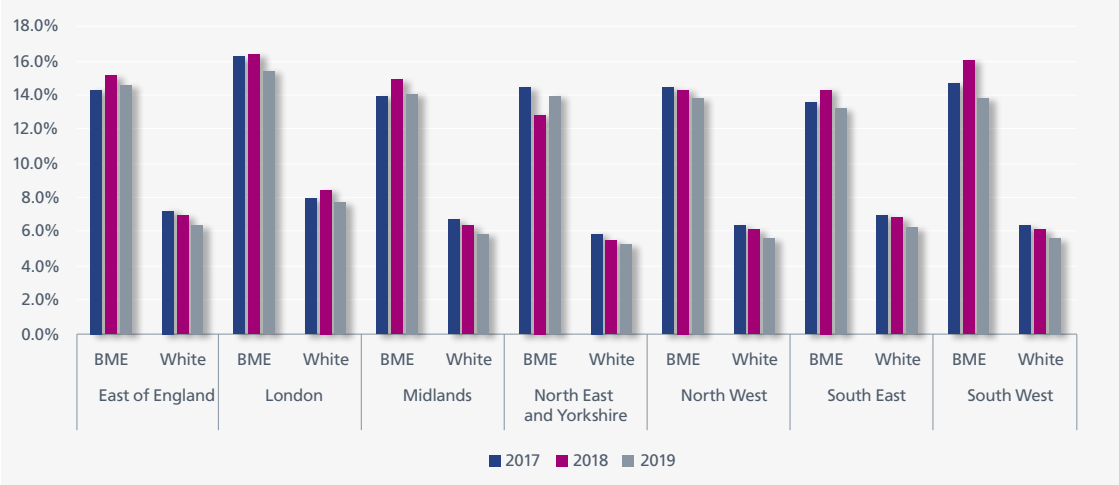
Key supportive data

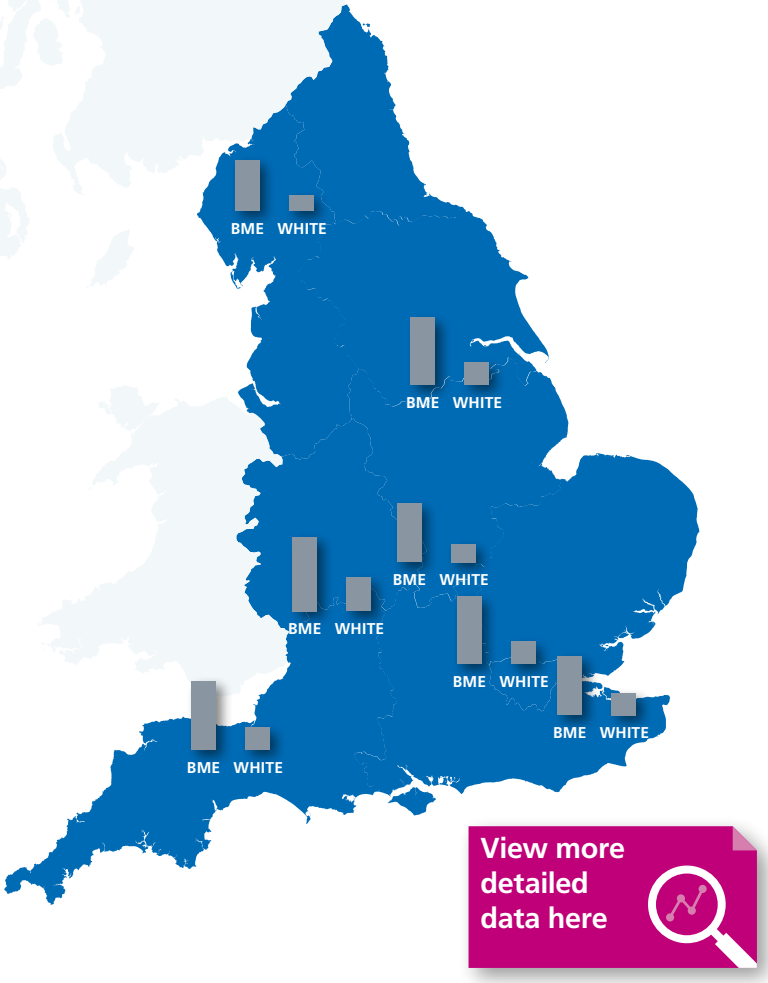
Figure 9

Percentage of BME staff that personally experienced discrimination at work from a manager, team leader or other colleagues by region: 2017 – 2019:

As a region, London had the highest percentage of BME staff and white staff that had experienced discrimination at work from a manager, team leader or other colleagues.

10.2% of BME staff and 4.4% of white staff in CCGs personally experienced discrimination at work from a manager, team leader or other colleagues.





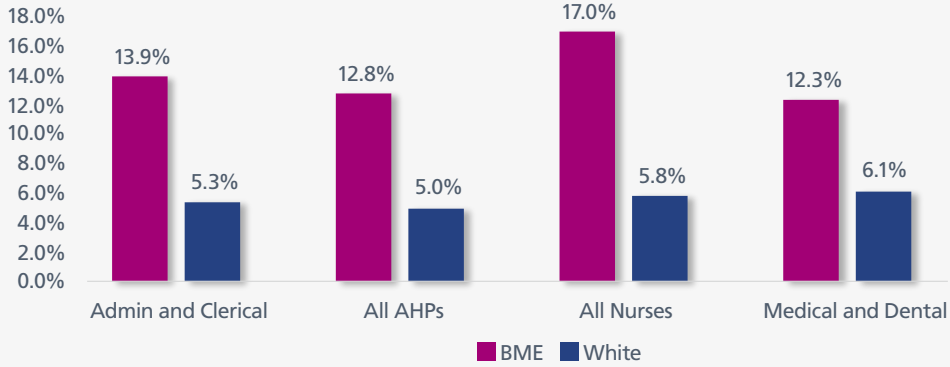
WRES indicator 8

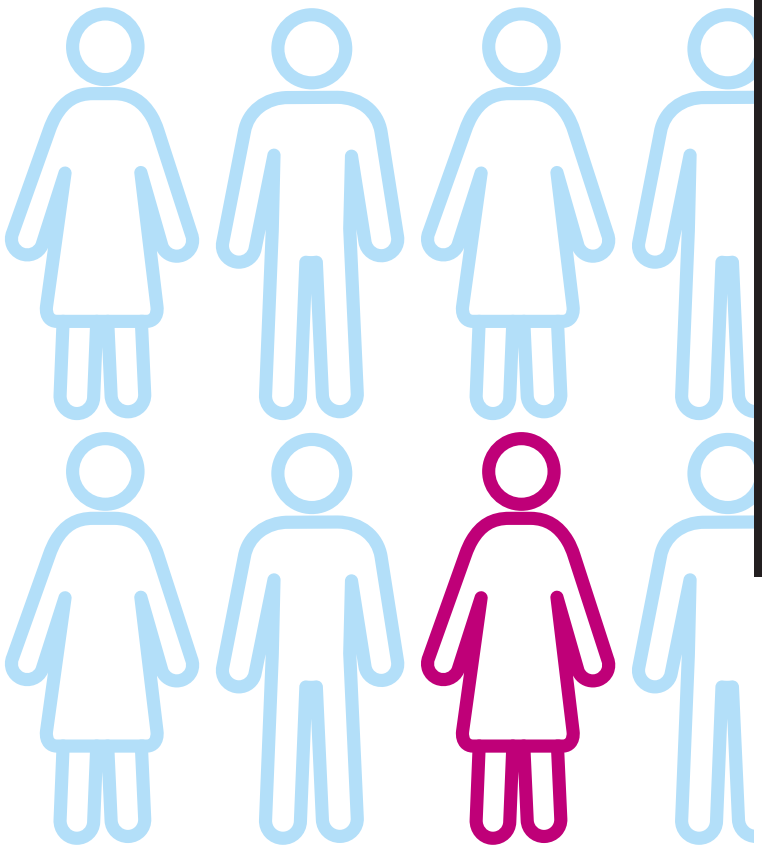
Key supportive data

Figure 10

Percentage of staff who experienced discriminations at work from – a manager team leader or other colleagues by staff group (2019)

BME nurses had the highest proportion of staff that experienced discrimination at work from a manager, team leader or other colleagues.





View more detailed data here

WRES indicator 9

Key supportive data

Table 7

Percentage of board members by ethnicity compared to BME workforce within NHS trusts by region (2020)

In all regions, there is a lower proportion of BME people on boards compared to proportion of BME staff.

Region	White	BME	Unknown	BME staff
East of England	89.4%	5.8%	4.8%	22.3%
London	74.9%	19.6%	5.4%	46.6%
Midlands	84.2%	11.2%	4.6%	20.4%
North East and Yorkshire	89.1%	6.0%	4.9%	11.3%
North West	88.2%	8.4%	3.4%	12.2%
South East	81.0%	10.6%	8.4%	20.6%
South West	91.0%	3.9%	5.1%	12.0%

Table 8

Percentage (number) of BME board members across NHS trusts: 2016 – 2020

There has been a decrease in the number and proportion of trusts with zero BME representation on the board. There were 22 trusts with four or more BME board members, compared to seven trusts in 2016.

	2016	2018	2019	2020
0 BME board members	43.5% (84)	41.6% (96)	32.2% (73)	23.4% (52)
1 BME board member	37.3% (72)	33.3% (77)	34.8% (79)	39.2% (87)
2 BME board members	10.9% (21)	12.6% (29)	19.8% (45)	16.7% (37)
3 BME board members	4.7% (9)	8.2% (19)	9.7% (22)	10.8% (24)
4 BME board members	2.6% (5)	2.6% (6)	2.2% (5)	5.4% (12)
5 BME board members	1.0% (2)	1.3% (3)	0.4% (1)	4.1% (9)
More than 5 BME board members	0.0% (0)	0.4% (1)	0.8% (2)	0.5% (1)

View more detailed data here

WRES indicator 9

Key supportive data

Figure 11

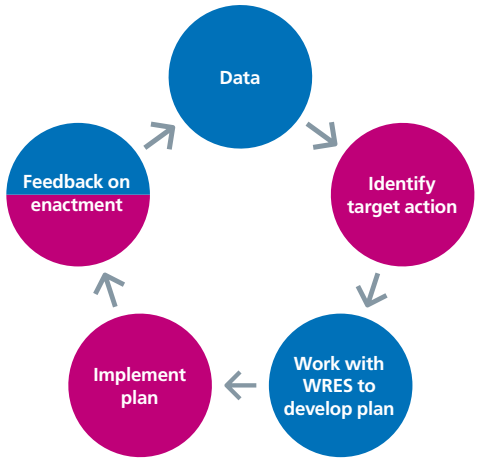
Numbers of BME board members by region: 2018 – 2020

There was a total of 61 more BME board members across all NHS trust in 2020 compared to 2019. This represents a 22.3% increase in the gross number of BME representation at boards across England. All regions saw an increase in the overall number of BME board members.

The number of executive board members across NHS trusts increased by 26 in 2020, compared to 2019. London had the biggest increase over that period, with 13 more BME executive board members. There has been an increase of 35 non-executive board members across all NHS trusts in England.

Conclusion and next steps

This report contains some evidence of modest improvement, and that is testament to the work done both nationally and locally to de-bias recruitment and disciplinary systems; to increase senior representation; and to increase the numbers of BME staff accessing non-mandatory training and CPD. It is, however, still not enough.



Now is the time to translate the data to actions. In light of the disproportionate impact of COVID-19 on BME people, not least in our workforce, there is no time to waste in eliminating inequity and discrimination in our workplaces. The pandemic did not create race inequality, but it has thrown it into sharp relief. For those who follow the data and have been reading the WRES reports for the last five years, the unequal distribution of suffering between white and BME people will come as no surprise.

The plan of work (please see diagram left) for the WRES is to pivot significantly towards actions that begin to reverse these widespread racial disparities. Programmes like WRES operate nationally, but change needs to be made locally. The vision is that WRES (blue circles) will support organisations (pink) to understand their data and then to work with them through the regional networks to develop robust action plans in each organisation.

These plans will be based on the commitments in the People Plan and organisations will work with the WRES team resources to identify both the plan and the appropriate monitoring metrics. This will then be implemented and the learning from this process will be shared with the WRES team. The subsequent annual data gathering will identify how successful the actions have been in addressing the intended targets, and the cycle restarts. The plans developed will be held as a repository by WRES for future adoption and adaptation as necessary for other organisations with similar problems. WRES will thus become a vibrant library both of data and of actions to help move the dial of long-standing racial inequality.

Areas for action mapped to WRES indicators

Indicator	Actions
Percentage of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce	• Increase BME representation at AFC band 8 level and above. • Address the wide variation in BME under-representation according to region and trust type implementing tailored solutions to local population and workforce.
Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants	• Development of BME talent in the employment pipeline. • Overhauling recruitment practices to ensure the workforce reflects the diversity of their community, and to do this at pace and scale.
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	• Understanding the reasons for the reduction of disciplinary proceedings. • Eliminating the ethnicity gap in formal disciplinary processes is a vital required action of the People Plan and studying the organisations which have made the most headway and developing summaries of what has proved most effective. • Reporting on the outcomes of disciplinary action, stratified by race.
Relative likelihood of white staff accessing non–mandatory training and continuous professional development (CPD) compared to BME staff	• Understanding the reasons for the improvement in training and identifying what has proved effective in successful organisations. • Understanding why there remains a disparity in career progression and promotion for BME staff despite this improvement in training access.
Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	• Report on strategies to target the increasing abuse of frontline staff in line with Assaults on Emergency Workers (Offences) Act 2018.
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	• Development of a written policy on reporting, dealing with bullying and harassment at work and communicating the policy and procedure to staff (as per the RCN Bullying and Harassment Advice Guide). • Development of civility and respect toolkit as per the People Plan.
Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	• Ensuring transparency and positive action as per the People Plan, which emphasises the importance of staff feeling a sense of belonging to their organisation • Working towards the The Model Employer Framework (2019).
In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues	• Trusts need to be proactive and preventative in tackling discrimination rather than responding to individual concerns or grievances. • The People Plan emphasises the need for organisation to develop system-level models of recruitment and retention, accordingly there should be focus on how to improve the way appraisals, feedback from interviews and performance assessments are undertaken. • Increasing training programme for freedom to speak up guardians on the topic of workplace race equality as per People Plan.
Percentage difference between the organisation's board voting membership and its overall workforce	• As set out in the 'NHS provider board membership and diversity survey: findings', improving leadership diversity is a significant priority for NHS Improvement and should be for every NHS board. • Working towards the percentage of BME board membership to match the proportion of BME staff in the workforce has been set.

Best performing organisations by WRES indicator

Indicator 5

- Airedale NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Kent Community Health NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Sheffield Children's NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- The Christie NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust

Indicator 6

- Cambridgeshire Community Services NHS Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Solent NHS Trust
- South Central Ambulance Service NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Indicator 7

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Devon Partnership NHS Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- The Christie NHS Foundation Trust
- West Suffolk NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Indicator 8

- Cambridgeshire Community Services NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Liverpool Women's NHS Foundation Trust
- North West Boroughs Healthcare NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- The Christie NHS Foundation Trust

Indicator 9

- Barnet, Enfield And Haringey Mental Health NHS Trust
- Coventry And Warwickshire Partnership NHS Trust
- East London NHS Foundation Trust
- Kent And Medway NHS And Social Care Partnership Trust
- Kingston Hospital NHS Foundation Trust
- London Ambulance Service NHS Trust
- North Middlesex University Hospital NHS Trust
- Oxleas NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- South West London And St George's Mental Health NHS Trust

Least well performing organisations by WRES indicator

Indicator 2

- Brighton And Sussex University Hospitals Nhs Trust
- Countess of Chester Hospital NHS Foundation Trust
- Cumbria, Northumberland, Tyne And Wear NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- Gateshead Health NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

Indicator 3

- Avon And Wiltshire Mental Health Partnership NHS Trust
- Devon Partnership NHS Trust
- Hounslow And Richmond Community Healthcare NHS Trust
- Kettering General Hospital NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- South London and Maudsley NHS Foundation Trust
- Southern Health NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust

Indicator 5

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Greater Manchester Mental Health NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Lincolnshire Partnership NHS Foundation Trust
- London Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Indicator 6

- Dorset County Hospital NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northampton General Hospital NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Royal Devon and Exeter NHS Foundation Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- The Shrewsbury and Telford Hospital NHS Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Walsall Healthcare NHS Trust

Indicator 7

- Birmingham Community Healthcare NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- London Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Northampton General Hospital NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

Indicator 8

- Bolton NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northampton General Hospital NHS Trust
- Northern Devon Healthcare NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Walsall Healthcare NHS Trust
- Yorkshire Ambulance Service NHS Trust

Annex A: The WRES indicators (2020)

	Workforce indicators For each of the four workforce indicators, ***compare the data for white and BME staff***
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-clinical staff • Clinical staff, of which – Non-medical staff – Medical and dental staff *Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.*
2	Relative likelihood of staff being appointed from shortlisting across all posts *Note: This refers to both external and internal posts*
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.*
4	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, ***compare the outcomes of the responses for white and BME staff***
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, ***compare the difference for white and BME staff***
9	Percentage difference between the organisation's board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board

Meeting Title:	Trust Board Meeting
Date of Meeting:	31st March 2021
Document Title:	**Proposed modification of the NHS provider licence standard conditions: Condition G4 (fit and proper persons)**
Responsible Director:	Patricia Miller, Chief Executive
Author:	Trevor Hughes, Head of Corporate Governance.

Confidentiality:	*If Confidential please state rationale: Not Confidential*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
None – this paper is for discussion by the Board		

Purpose of the Paper	NHS Improvement published a statutory consultation Notice under section 100 of the Health and Social Care Act 2012 (the 2012 Act) giving notice of a proposed modification to the standard conditions of the NHS provider licence; particularly Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the FPP Regulations) on 22nd February 2021. License condition G4 provides for fit and proper persons requirements to be satisfied by Directors and those operating in equivalent roles within the NHS. Technical changes to License Condition G4 are being proposed in order to promote consistency with the Regulation 5 requirements. It is further proposed that the requirement is extended to include Foundation Trust Governors.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Changes proposed would extend the scope of the fit and proper person test as set out in the license condition to reflect the regulatory requirements. Trusts are required to comply with the regulatory requirement to ensure Directors and Director equivalents meet the requirement already and the change is to reflect the requirement within the license condition. The need to ensure that contractual arrangements to deal with 'unfit' directors has also been removed as license holders are prohibited from appointing or having in office, an unfit Director. Monitor's discretion to authorise an exception to the fit and proper person requirements had not been exercised and is to be removed. The prohibition on holding office by any person disqualified under the Company Directors' Disqualification Act 1986: • Extends beyond the legislative framework for governors and it is proposed that this requirement is removed in relation to governors; • Is contained within the fit and proper person test and regulatory							

	requirements for directors. The consultation will close on 29th March 2021 and stakeholders are invited to respond to the following consultation questions via an online survey: https://www.engage.england.nhs.uk/survey/proposed-modification-of-the-nhs-provider-licence, or by email to nhsi.g4responses@nhs.net **1.** Do you object to the proposed technical amendment to modify condition G4 of the NHS provider licence? **2.** If so, what are your reasons? **3.** Are there any equality issues that arise (positive or negative) in relation to this proposal? In particular, would this proposal have an impact on any groups of persons sharing a protected characteristic, as set out in the Equality Act 2010? **4.** If yes, please outline any potential issues.
Action recommended	The Trust Board is asked to note the NHSI consultation on minor and technical changes to the provider license general condition 4 and to provide a response to the consultation questions if appropriate.

Governance and Compliance Obligations

Legal / Regulatory	Y/N	Proposed minor technical changes to License Condition 4
Financial	Y/N	No
Impacts Strategic Objectives?	Y/N	No
Risk?	Y/N	No
Decision to be made?	Y/N	No
Impacts CQC Standards?	Y/N	No
Impacts Social Value ambitions?	Y/N	No
Equality Impact Assessment?	Y/N	No
Quality Impact Assessment?	Y/N	No

Proposed modification of the NHS provider licence standard conditions: Condition G4 (fit and proper persons)

Consultation notice

22 February 2021

About this document

1. This statutory consultation notice published by Monitor under section 100 of the Health and Social Care Act 2012 (the 2012 Act) gives notice of a proposed modification to the standard conditions of the NHS provider licence. It should be read in conjunction with the annexes which are supporting documents.

2. Monitor and the NHS Trust Development Authority operate as an integrated organisation known as NHS Improvement. In this document references to 'NHS Improvement' should be read as references to Monitor and/or the Trust Development Authority as appropriate to the context. References to 'directors', even where expressly stated, include all those performing equivalent or similar functions.

Background

3. Providers of healthcare services for the NHS must ensure that their directors (or directors and governors in the case of NHS foundation trusts) satisfy specified requirements. In particular, directors must meet the fit and proper person test set out in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the FPP Regulations). A copy of regulation 5 of the FPP Regulations can be found at Annex B.

4. NHS foundation trusts and most independent providers of health care services for the NHS must be licensed by Monitor. NHS trusts are not required to hold a licence but are bound by most of the standard conditions of the provider licence, including condition G4. Condition G4 makes provision about fit and proper persons, and therefore applies to NHS foundation trusts, NHS trusts and all licensed independent providers of health services for the NHS.

5. The proposed amendments to condition G4 would provide for consistency with the FPP Regulations.

Proposed modification to condition G4

6. NHS Improvement proposes modifying standard condition G4 of the provider licence: Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions). A copy of condition G4 in its current form can be found at Annex A. Our proposal is largely a technical amendment designed to align condition G4 with the fit and proper persons requirements set out in the FPP Regulations.

Reason for the proposed modification

7. Licence condition G4 applies to all providers holding an NHS provider licence and, by way of directions, also applies to NHS trusts. It requires that providers ensure that their directors and governors meet appropriate standards of personal behaviours and technical competence. The objective is to prevent an unfit person from holding office as a director or governor.

8. Since publication of the NHS provider licence, regulation 5 of the FPP Regulations has come into force. Regulation 5 sets out a fit and proper person's test (the FPP test) which applies to directors of all NHS providers registered with the Care Quality Commission, which includes all licence holders and other organisations to which licence conditions apply.

9. To ensure consistency of approach with the FPP Regulations, we propose making some technical amendments to condition G4.

10. Although the FPP Regulations do not apply to governors of NHS foundation trusts, we also propose updating the provisions of condition G4 relating to governors to reflect current practices.

Effect of the proposed modification

Provisions relating to directors

11. While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:

    a. qualifications, competence, skills, experience and ability to properly perform the functions of a director
    b. issues of serious misconduct or mismanagement and
    c. disbarment in relation to safeguarding vulnerable groups and disqualification from office.

12. In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.

13. The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.

14. The effect of the modification is also to remove provisions which have become redundant and brings provisions in line with current working practices, details of which are set out in paragraphs 15 to 18 below.

Provisions relating to governors

15. The FPP Regulations do not apply to governors of NHS foundation trusts. The effect of the proposed modification (as it applies to governors) would be limited to bringing the provisions in line with current working practices, as set out in paragraphs 16 to 18 below, and to make minor changes to the wording to provide greater clarity.

Provisions relating to directors and governors

16. The proposed modification would remove two provisions which are either redundant or have limited application.

17. The first of these provisions is the reference to Monitor's discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.

18. The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors' Disqualification Act 1986. As this provision expressly relates to directors' fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors. For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

Form of the proposed modification to licence condition G4

19. The proposed modification to condition G4 is in the form set out below:

PROVIDER LICENCE

Licence Condition G4

Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:

   (a) a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

   (b) a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

   (c) a person who has made a composition or arrangement with, or granted

a trust deed for, that person's creditors and has not been discharged in respect of it;

(d) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:

(a) an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or

(b) an organisation which is a body corporate, or a body corporate with a parent body corporate:

i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;
iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;
iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
v. which passes any resolution for winding up;
vi. which becomes subject to an order of a Court for winding up; or
vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

The consultation process

Statutory consultation and objection process

20. Any proposals to modify the standard conditions of the NHS provider licence are subject to a statutory consultation process under the 2012 Act. This provides an opportunity for licence holders to express their views on, and to object to, the proposals. Further information on the statutory consultation and objection process can be found in Annex C.

21. The 2012 Act sets out the statutory process for challenging a proposed modification to the NHS provider licence. If licence holders object to the proposal, and the number of objections reaches a certain threshold, NHS Improvement may not progress with the proposed modification without a reference to the Competition and Markets Authority or further statutory consultation.

Who can object to the proposed modifications?

22. While responses from stakeholders other than licence holders will inform any decision about the proposed modification, only objections from licence holders will count towards the objection threshold.

Impact assessment

23. Under section 69 of the 2012 Act, Monitor is required to carry out an impact assessment where proposals are likely to involve a major change in the standard conditions of the NHS provider licence. This proposal involves only minor and technical changes to the NHS provider licence which are necessary to bring the licence into line with existing legislative requirements. On that basis, an impact assessment is not required.

24. We have carried out an assessment of the equality and health inequalities impact of these proposals and have not identified any issues. We would welcome comments from consultees.

Consultation questions

1. **Do you object to the proposed technical amendment to modify condition G4 of the NHS provider licence? **All consultation responses will be taken into account but only objections from licence holders will count towards the objection threshold***
2. **If so, what are your reasons?**
3. **Are there any equality issues that arise (positive or negative) in relation to this proposal? In particular, would this proposal have an impact on any groups of persons sharing a protected characteristic, as set out in the Equality Act 2010?**
4. **If yes, please outline any potential issues.**

Responding to the consultation

25. If you wish to respond to this consultation, please do so by **midnight on Monday 29 March 2021.** You may submit your response via our online survey: https://www.engage.england.nhs.uk/survey/proposed-modification-of-the-nhs-provider-licence, or by email to nhsi.g4responses@nhs.net. The address for postal responses can be found at the end of this document.

26. If you are responding to this consultation on behalf on an organisation, please confirm that you are authorised to do so.

27. Please email nhsi.g4responses@nhs.net if you have any questions or any difficulty accessing the survey. Please let us know (by emailing nhsi.g4responses@nhs.net) if all or part of your response or identity is confidential so that we can exclude this from any published summary of responses. We will do our best to meet all requests for confidentiality but, because NHS Improvement is a public body subject to the Freedom of Information Act, we cannot guarantee that we will not be obliged to release your response (potentially including your identity) or part of it even if you say it is confidential.

Annex A: NHS Provider Licence General Condition G4: Fit and Proper Persons as Governors and Directors

The Provider Licence

Condition G4: Current form

Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.

4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is:

(a) an individual;

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Annex B: Relevant legislation: the fit and proper persons tests

Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (FPP Regulations)

5.—

1. This regulation applies where a service provider is a body other than a partnership.
2. Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual—
    a. as a director of the service provider, or
    b. performing the functions of, or functions equivalent or similar to the functions of a director.
3. The requirements referred to in paragraph (2) are that—
    a. the individual is of good character,
    b. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
    c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
    d. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
    e. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.
4. In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

5. The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or —
    a. the information specified in Schedule 3, and
    b. such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
6. Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must—
    a. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
    b. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

SCHEDULE 4

Good character and unfit person tests

PART 1
Unfit person test

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

PART 2
Good character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Annex C: The statutory consultation process and objection threshold

Consultation process

The Health and Social Care Act 2012 specifies that Monitor must consult on any proposed modification to the standard conditions of the provider licence with:

- every licence holder
- the Secretary of State
- NHS England
- every CCG
- the CQC and its Healthwatch England Committee.

Monitor may only modify the standard conditions of the licence (without reference to the Competition and Markets Authority) if:

a. No objections are received from licence holders within the notice period (a minimum of 28 days); or
b. Where one or more licence holders object within the notice period, the objection threshold and share of supply threshold are not met.

The objection threshold is met if 20% or more licence holders object to the proposals. The share of supply threshold is met if the percentage of licence holders, weighted according to share of supply is 20% or more.

Who can object?

All responses to the consultation will be taken into account but only objections from licence holders will count towards the objection threshold and therefore determine whether NHS Improvement can make the proposed modification without further consultation or reference to the Competition and Markets Authority.

Any objection must be made by a person who is authorised to represent the licence holder. Providers should ensure that there are proper internal processes for managing this.

Licence holders should, if they object to the proposals, provide reasons. Failure to do so will not invalidate the objection but it may have an impact on our assessment of the objection.

Contact us:
nhsi.g4responses@nhs.net

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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Publication approval reference: PAR046

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**31 March 2021**
Document Title:	**Register of Interests and Register of Gifts and Hospitality**
Responsible Director:	**Patricia Miller, Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	2020	Review progress with the implementation of electronic recording of interest declarations in 2021.
Risk and Audit Committee	**23 March 2021**	Recommended to the Board

Purpose of the Paper	To receive and note for information and assurance.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The Trust is obliged to comply with national guidance published in 2016/17 regarding declarations of interests and a register of gifts and hospitality received by staff. The Trust Secretariat therefore collects information from staff and complies a register of interests and if declared gifts and/or hospitality. Employees are also required to declare any conflicts of interest against agenda items for each meeting and if declared these are recorded for each meeting. The committee will recall discussion of plans to enable staff to make a declaration via the Electronic Staff Record (ESR) and that this system would prompt staff to do so. The Trust Secretariat, supported by the ESR team, launched the system for senior staff in February 2021. In 2021, all staff from Band 8a and above, Consultants and Directors were asked for their declarations: • 337 staff were asked via ESR • 100 responses have been received to date (30%) • Of the responses received, 10 staff have declared interests (details attached).							

Interest Declared	Interest Category	Interest Situation	Interest Description
Y	Financial interests	Clinical private practice	I have started doing private practice as part of the Dorchester Anaesthetists LLP, with a 20% share as of January 2021.
Y	Financial interests	Shareholdings and other ownership interests	I hold small numbers of shares in some pharmaceutical or medical equipment companies, but these are either part of funds that I do not control which companies, or managed by an independent investment company (ie I don't choose which companies)
Y	Non-financial professional interest	Loyalty interests	I am a Director (Trustee) of the Dorset Health Trust. DHT is a local charity that distributes over £300,000 per year to local Health Organisations. The charity has made large contributions to Dorset County Hospital

Y	Financial interests	Shareholdings and other ownership interests	co director in Pearls clinical eHealth Wisdoms LTD Offering education programmes for HCP and people with long term health conditions and care pathway development in conjunction with industry partners.
Y	Indirect interests	Loyalty interests	Quay Healthcare Ltd (husbands company), same as last year.
Y	Non-financial personal interests	Loyalty interests	I am a trustee with Wessex 4x4 Response which is a registered charity. (Charity number 1159765) We provide emergency logistics to cat 1 and 2 organisations. During bad weather we are often part of the team to ensure staff and patients can move safely in and out of the hospital.
Y	Financial interests	Clinical private practice	BMI Winterbourne
Y	Financial interests	Clinical private practice	I run a private physiotherapy practice, Brookes Physiotherapy as well as maintaining my NHS roles. This business does not compete in any way with services provided by the NHS. I therefore perceive there to be no conflict of interest.
Y	Financial interests	Loyalty interests	Trustee of Dorchester Baptist Church - DCHFT hires rooms for training from Dorford Lettings
Y	Non-financial personal interests	Loyalty interests	Partner is Deputy Chief Inspector at CQC

During 2021, it is planned to extend the requirement to make declarations of interest to all staff.

The Register of Interests for the Board of Directors and Council of Governors are also attached.

There was only one declaration for receipt of gifts or hospitality during the financial year 2020/21:

Date	Details of Hospitality/Gift Offered	Name/Company of Person Offering Gift/Hospitality	Approx Value	Reason for Gift/Hospitality Being Offered
16 November 2020	Series of short pharma education courses	Not stated	Not stated	Related to specialist area

ESR has the functionality to record the receipt of gifts and hospitality by staff in addition to making any declarations of interest. Trust Secretariat will work with the ESR and Communications team to ensure that staff understand the requirement to declare throughout 2021.

Action recommended

The Risk and Audit Committee is asked to:

1. **APPROVE** the report and planned action to promote staff awareness of the need to submit declarations of interests and gifts or hospitality received.

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to comply with the guidance may result in actions being enforced on the Trust.
Financial	Y	Compliance with guidance on the receipt of gifts and hospitality and protects decision makers and those with responsibility for authorising public body expenditure.
Impacts Strategic Objectives?	N	
Risk?	Y	Effective management of declared interests supports risk mitigation and compliance with the Trust's Standing Financial Instructions.
Decision to be made?	N	
Impacts CQC Standards?	Y	An effective governance process for the management of staff interests and the receipt of gifts and hospitality supports compliance with the Trust's provider license and registration with the CQC.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DCHFT Board of Directors Declarations of Interest 2021/22
As at 24 March 2021

Name	Interest Description	Last Updated Date
Goddard, Mr. Paul Leslie	My wife works for Solent NHS FT, a Community and Mental Health provider based in Hampshire.	08/02/2021
Hutchison, Professor Alastair James	I have no interests to declare	03/02/2021
Johnson, Mr. Nicholas	Directorships: DCH SubCo Ltd Dorset Estates Partnership LLP	18/03/2021
Lucey, Mrs. Nicola Louise (Nicky)	I have no interests to declare	23/03/2021
Miller, Mrs. Patricia Ann Cecilia	Member of the NHS Assembly NHS Providers Board Trustee Board Director - Race and Health Observatroy Member of the National People Board Member of the South West People Board Member of the NHS Chief Executive Advisory Group Member of the NHS CHief Executive Advisory Group for Elective Recovery	24/03/2021
Robotham, Mrs. Inese	I have no interests to declare	04/02/2021
Addison, Mr. Mark	Vice Chair for the Charity for Civil Servants; supporting Civil Servants experiencing difficulty - not directly involved in health or social care provision.	17/03/2021
Atkinson, Professor Susan (Sue)		
Blankson, Ms. Margaret Ekua		
Gillow, Mrs. Judith (Judy)	Lay Board Member of West Hampshire CCG finishes March 2021 Non–Executive of combined Hampshire and IOW CCG. Commences April 2021 Specialist Advisor, Care Quality Commission. Well led inspections temporarily suspended due to COVID 19	23/03/2021
Metcalfe, Mr. Ian Michael	Board member of Activate, an arts charity in Dorchester, who have worked with DCH on arts projects for patients. Chair of Platinum Skies Living Limited (PSLL), a registered Social Landlord building and managing Shared Ownership and keyworker affordable housing. PSLL is a subsidiary of Affordable Housing & Health (AHH) which has built senior living and care homes, in some cases on NHS land.	17/03/2021
Tilton, Mr. Stephen James	College Yard Limited DCH Subco Ltd Loders Parish Council Member	18/03/2021

Underwood, Mr. David Charles	Chairman of Royal British Legion Club (West Hill) Ltd (since 2012); Chair SW Computing Hub Strategy Board (from May 2021); Associate to the Board of Exeter College (since October 2020); SW Business Council Policy Advisory Board Member (since Dec 2019).	19/03/2021
Slough, Mr. Stephen	Position held with commissioning body: Chief Information Officer – Dorset CCG Position held with other NHS provider: Chief Information Officer – Dorset HealthCare Board Advisor, Necenti Labs. Technology company with an algorithm that interprets epigenetic biomarkers to enable tailored care packages	18/03/2021
Hallett Ms. Emma	I have no interests to declare	17/03/2021

DCHFT Council of Governors Declarations of Interest 2021/22
As at 23 March 2021

Title	Firstname	Lastname	Constituency/Organisatio	Interest Declared	Date of Declaration
Mr	Simon	Bishop	East Dorset	Nil to Declare	05/03/2021
Mrs	Sarah	Carney	West Dorset	Bridport Town Councillor	22/03/2021
Dr	David	Cove	West Dorset	1) Chairman of Citizens Advice Central Dorset 2) Trustee of the Dorset Health trust	05/03/2021
Mr	Wally	Gundry	West Dorset	Nil to Declare	05/03/2021
Mrs	Kathryn	Harrison	West Dorset	Nil to Declare	05/03/2021
Mrs	Naomi	Patterson	West Dorset	Healthwatch and Our Dorset member	05/03/2021
Mr	David	Tett	West Dorset	Nil to Declare	05/03/2021
Mrs	Margaret	Alsop	Weymouth & Portland	Nil to Declare	05/03/2021
Mr	Mike	Byatt	Weymouth & Portland	Nil to Declare	10/03/2021
Mr	Stephen	Mason	Weymouth & Portland	Nil to Declare	05/03/2021
Mrs	Marion	Levick	Weymouth & Portland	Nil to Declare	05/03/2021
Ms	Sharon	Waight	Weymouth & Portland	Employed by Bournemouth University. Band 5 COVID 19 healthcare vaccinator at Dorset Healthcare University Trust Bank.	18/03/2021
Mrs	Christine	McGee	North Dorset	Nil to Declare	05/03/2021
Dr	Maurice	Perks	North Dorset	I am a Director of Mopenconsulting Limited, which has no commercial interest or affiliation with DCH Trust I am a Trustee of the Sturminster Newton Learning Centre, which has no commercial interest or affiliation with DCH Trust	10/03/2021
Ms	Tracy	Glen	Staff	Nil to Declare	17/03/2021
Ms	Annette	Kent	Friends of DCH	(currently stood down, and role being covered by joint Appointed Governor Barbara Purnell)	
Ms	Barbara	Purnell	Friends of DCH	Nil to Declare	05/03/2021
Mr	David	Thorp	Age UK	I am the Chief Executive of Age UK North, South and West Dorset. Therefore, declare this as an outside employment interest. I am a director in Age UK Dorset Enterprises Ltd (a trading arm of the charity) and therefore also declare this as an outside employment interest.	05/03/2021
Cllr	Tony	Alford	Dorset Council	Member of Dorset Council	05/03/2021
Mrs	Davina	Smith	Weldmar	Trustee of Weldmar Hospicecare In Dorset	05/03/2021

Meeting Title:	Trust Board
Date of Meeting:	31st March 2021
Document Title:	**Proposed Committee Membership**
Responsible Director:	Mark Addison, Trust Chair Patricia Miller, Chief Executive
Author:	Trevor Hughes, Head of Corporate Governance

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Non-Executive Directors' Meeting	March 2021	Proposal supported

Purpose of the Paper	The purpose of this paper is to set out proposed Non-Executive Director (NED) membership of the Board sub-committees following the recent appointment of a new Non-Executive Director in order to maximise the knowledge, skills and experience the Non-Executive team brings to the Board and in order to ensure an equitable workload. The Board is asked to discuss and approve the proposal.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	A review of Board sub-committee membership at this time is appropriate as: • Interim committee membership arrangements have been operating during the period to recruit to the NED vacancy resulting in inequitable workloads within the NED team; • Interim supplementary NED lead roles have been undertaken during the recruitment period; • A new NED has recently been appointed to the vacancy • The timing is consistent with the annual committee review of effectiveness • The DCHFT strategy and strategic objectives have been reviewed and sub-committee programmes of work will be aligned to this over the coming months. The sub-committee membership proposal aims to maximise benefit to the Trust by ensuring appropriate membership and maximises NED knowledge, skills and experience. The proposal also aims to deliver a more equitable workload for NED team members.							
Action recommended	The Board of Directors is recommended to: 1. **Discuss** the benefits and changes contained within the proposal; making amendments if necessary; 2. **Approve** the proposal.							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	The Trust Board is required to ensure that the arrangements it establishes demonstrate that the organisation is 'Well Led'.
Financial	Y/N	No
Impacts Strategic Objectives?	Y/N	Appropriate alignment of NED knowledge, skills and experience within board sub-committees will support scrutiny and delivery of the refreshed

		strategic objectives of the Trust.
Risk?	Y/N	Appropriate alignment of NED knowledge, skills and experience within board sub-committees will support scrutiny of risk mitigations and assurance.
Decision to be made?	Y/N	The proposal is consistent with the Trust's workforce risk appetite statement to maximise potential, support the Trust's values and strategic objectives.
Impacts CQC Standards?	Y/N	The proposal supports delivery of the 'Well Led' standard by maximising the use of NED knowledge, skills and experience
Impacts Social Value ambitions?	Y/N	No
Equality Impact Assessment?	Y/N	The proposal aims to deliver an equitable workload for members of the NED team
Quality Impact Assessment?	Y/N	No

Committee Memberships

Key:

Added to meeting
Discretionary attendance / further discussion
Removed from meeting

	Current		Proposed		Commentary
Risk and Audit Committee Quorum = 2 NEDs	**Chair**	Ian Metcalfe	**Chair**	Ian Metcalfe	
	NEDs	Sue Atkinson Judy Gillow (Quality) Stephen Tilton (FPC) Dave Underwood (Charity)	**NEDs** Quorum = 2 NEDs and 2 Execs	Sue Atkinson Margaret Blankson (PCC) Judy Gillow (Quality) Stephen Tilton (FPC) Dave Underwood (Charity)	Committee Chairs to provide risk and governance assurance.
	Exec's CFO and either MD or CNO to attend	Paul Goddard Nick Johnson Nicky Lucey Inese Robotham Stephen Slough Alastair Hutchison Patricia Miller (Annual Governance Statement)	**Exec's** CFO and either MD or CNO to attend	Paul Goddard Nick Johnson Nicky Lucey Inese Robotham – as requested Stephen Slough – as requested Alastair Hutchison Patricia Miller (Annual Governance Statement)	DCH Subco to report to RAC rather than FPC – removes the conflict of ST as Subco Director reporting to FPC which he Chairs DEP Joint Venture to report to RAC on activities and approvals Management of BAF risks to move to Committees – oversight to be retained by RAC with Assurances on mitigations provided by Committee Chairs

	Current		Proposed		Commentary
					following Committee discussion.
Finance and Performance Committee	**Chair**	Stephen Tilton	**Chair**	Stephen Tilton	
Quorum = 2 NEDs and two Execs	**NEDs**	Judy Gillow (Quality) Victoria Hodges (WFC) Ian Metcalfe (RAC) Dave Underwood (Charity)	**NEDs** Quorum = 2 NEDs and two Execs	Judy Gillow (Quality) Margaret Blankson (PCC) Ian Metcalfe (RAC) Dave Underwood (Charity)	
	Exec's	Paul Goddard Nick Johnson Nicky Lucey (as required) Patricia Miller Inese Robotham CPO - Vacant	**Exec's**	Paul Goddard Nick Johnson Nicky Lucey (as required) Patricia Miller Inese Robotham CPO - Vacant	Unchanged
Quality Committee Quorum = 2 NEDs and 2 Execs (one must be MD or CNO)	**Chair**	Judy Gillow	**Chair**	Judy Gillow	
	NEDs	Sue Atkinson Ian Metcalfe (RAC) Stephen Tilton (FPC) Dave Underwood (Charity) Nick Johnson (as required)	**NEDs** Quorum = 2 NEDs and two Execs (one must be MD or CNO)	Sue Atkinson Ian Metcalfe Stephen Tilton (FPC) Dave Underwood (Charity) Nick Johnson (as required)	Dave Underwood – remove to equalise NED workload
	Exec's	Alastair Hutchison Nick Johnson Nicky Lucey Patricia Miller	**Exec's**	Alastair Hutchison Nick Johnson Nicky Lucey Patricia Miller	

	Current		Proposed		Commentary
		Inese Robotham		Inese Robotham CPO – Vacant	
People and Culture Committee Quorum = 2 NEDs and 3 Execs (COO, MD and CNO)	**Chair**	Victoria Hodges	**Chair**	Margaret Blankson	
	NEDs	Judy Gillow Ian Metcalfe	**NEDs** Quorum = 2 NEDs and 2 Execs (Either COO and/or MD and/or CNO)	Sue Atkinson Judy Gillow Ian Metcalfe Dave Underwood	Judy Gillow - ? attendance going forward due to workload Sue Atkinson added to equalise NED workload Dave Underwood added as FTSU NED lead
	Exec's	Paul Goddard Alastair Hutchison Nicky Lucey Patricia Miller Inese Robotham	**Exec's**	Paul Goddard Alastair Hutchison Nicky Lucey Patricia Miller Inese Robotham	
Charitable Funds Committee	**Chair**	Dave Underwood		Dave Underwood	
	NEDs	Mark Addison Judy Gillow Victoria Hodges		Mark Addison Judy Gillow Margaret Blankson (PCC)	Judy Gillow - ? attendance going forward
	Exec's	Nick Johnson Paul Goddard Nicky Lucey Inese Robotham			

	Current		Proposed		Commentary
DCH Subco Ltd	**Chair**	Stephen Tilton		Stephen Tilton	
	NEDs	-		-	
	Exec's	Nick Johnson		Nick Johnson	
Master Plan	**NEDs**	Stephen Tilton Ian Metcalfe Dave Underwood		Stephen Tilton Ian Metcalfe Dave Underwood	
		Nick Johnson		Nick Johnson	
Strategy	**NEDs**	Mark Addison Judy Gillow Sue Atkinson		Mark Addison Judy Gillow Sue Atkinson	
ED&I	**NEDs**	Margaret Johnson Stephen Tilton		Margaret Johnson Stephen Tilton	
Estates					

NED Workload Summary

Name	Chair of	Attends	Other Roles
Mark Addison	Trust		•
Judy Gillow	Quality Committee	• Risk and Audit Committee • Finance and Performance Committee • Charitable Funds Committee (clinical NED) • People and Culture Committee	• Vice Chair • Mortality
Victoria Hodges	People and Culture	• Finance and Performance Committee • Charitable Funds Committee	• Senior Independent Director
Sue Atkinson		• Risk and Audit Committee • Quality Committee • People and Culture Committee	• Senior Independent Director • Maternity • End of Life
Ian Metcalfe	Risk and Audit Committee	• Finance and Performance Committee • Quality Committee • People and Culture Committee	• Emergency Preparedness
Stephen Tilton	Finance and Performance Committee	• Risk and Audit Committee • Quality Committee	• DCH Subco Chair
Dave Underwood	Charitable Funds Committee	• Risk and Audit Committee • Finance and Performance Committee • Quality Committee • People and Culture Committee	• Freedom to Speak Up Lead
Margaret Blankson	People and Culture Committee	• Risk and Audit Committee • Finance and Performance Committee • Charitable Funds Committee	•